2013

EXPLORING THE HEALTH OF WOMEN WHO EXPERIENCED HOMELESSNESS DURING ADOLESCENCE

Claire M. Creamer
University of Rhode Island, ccreamer@ric.edu

EXPLORING THE HEALTH OF WOMEN WHO EXPERIENCED HOMELESSNESS DURING ADOLESCENCE.

BY

CLAIRE M. CREAMER

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

IN

NURSING

UNIVERSITY OF RHODE ISLAND

2013

DOCTOR OF PHILOSOPHY DISSERTATION

OF

CLAIRE M. CREAMER

APPROVED:

Dissertation Committee:

Major Professor: Ginette Ferszt

Diane Martins

Jasmine Mena

Nasser H. Zawia
DEAN OF THE GRADUATE SCHOOL

UNIVERSITY OF RHODE ISLAND

2013

Abstract

Homelessness remains a significant global issue with substantial health consequences related to the experiences of homelessness. The consequences for people who experience homelessness are typically associated with high levels of risk, violence, and negative health outcomes. Developmental levels and gender contribute significantly to outcomes. As a developmental stage, adolescence is a time of establishing healthy practices for adulthood. Adolescent experiences with homelessness have negative consequences for future health as well as some economic status. Homeless youth have been identified as a medically underserved and vulnerable population.

A significant body of literature has explored the outcomes of mental health, sexual practices, risky behaviors, and substance abuse related to adolescents who are homelessness. However, exploration of the lived experiences of adolescent females while homeless related to strengths used for caring for their health is limited. This includes a need to understand how women who experienced homelessness during adolescence engaged in health promotion and accessed health information. Adolescent females are at greater risk for acts of violence against them, have specific physical and emotional needs as well as perspectives regarding their health and well-being.

The purpose of this study was to explore how women who experienced homelessness during adolescence met basic health needs, utilized resources and negotiated met while trying to maintain their health.

A qualitative exploratory approach to inquiry using semi-structured interviewing was used with a purposive convenience sample of nine women obtained from a community-based agency. Inclusion was limited to women who experienced homelessness during

adolescence, defined as between the ages of 12-24, who are English speaking and not actively suicidal or psychotic. Qualitative content analysis (QCA) was used to analyze transcripts with attention to manifest and latent content. Processes to maintain trustworthiness were implemented.

Six categories were identified and two themes emerged from the analysis of the data. The categories are listed as (1) hunger; (2) staying safe, warm and rested; (3) keeping clean; (4) resourcefulness; (5) challenges encountered; (6) insights and recommendations. The two themes that emerged and were (1) survival takes precedence; and (2) remaining invisible.

Implications for nursing knowledge, practice and education were discussed. Recommendations included further research specific to female adolescents who are homeless, education of nurses and nursing students related to meeting the needs of female adolescents who are homeless, and policy implications.

Acknowledgments

This research would not have been possible without the support, guidance, and mentorship of so many individuals and I will do my best to acknowledge all of you. First and foremost I wish to begin by giving thanks to God for the many blessings he gives me each day. Secondly, I wish to acknowledge and thank the women who so graciously shared their stories and insights and contributed so greatly to this research. It would not have been possible without the benefit of your experiences. You will continue to be remembered in my thoughts.

I wish to acknowledge Professor Ginette Ferszt, College of Nursing, University of Rhode Island, major professor, for her guidance, constant support, and expertise with this study. Your professionalism, dedication, and selflessness is a such an inspiration to everyone who has the opportunity to work with you. I look forward to our ongoing collegial collaboration in the future. I also wish to acknowledge Professor Diane Martins, College of Nursing, University of Rhode Island, who also was a great source of encouragement, support and guidance in working with vulnerable populations. I am so appreciative of your knowledge love and dedication. I also wish to acknowledge the hard work and support of the remaining members of my dissertation committee; Professor Jasmine Mena, Psychology, University of Rhode Island; Professor Barbara Newman, Human Development and Family Studies, University of Rhode Island; Professor Joanne Costello, School of Nursing, University of Rhode Island and Rhode Island College. A special thank you to Bethany Fay and Kathy Thorsen for all of your help. Without the entire team this would not have been possible and I am so grateful.

To my husband David and our children Tanya and Lara there are no words to truly express how much you mean to me and for the years of unconditional love and understanding as we took this long journey together. My love and gratitude is unending. I look forward to special times once again. To the extended members of my family I am so grateful to all of you for your support and understanding. It has been a long road thank you for walking it with me.

To my many colleagues at Rhode Island College I thank you for taking this journey with me as well and providing the support and encouragement to keep going. I wish it was possible to name each of you individually; however the list would be too long. I do wish to acknowledge Dean Jane Williams, Chairperson Yolande Lockett, Karen Hetzel, Lynn Blanchette, Bethany Coia, Donna Huntley-Newby, Nicole Smith and Deb Servello.

I also wish to acknowledge the financial support of the Nursing Foundation of Rhode Island who provided a financial grant to assist in this research. Additionally, a note of thanks to The Blasdell Family who sponsored financial award along with the Caring Award in honor of Nancy Blasdell's mother. I was so fortunate to be the recipient of these grants. Thank you.

Dedication

This scholarly body of work is dedicated to Lucien S. Brouillard, my Papa. You were an amazing role model and father. Education was something that you impressed upon your children. You always put your children and family ahead of your own needs so your dreams of furthering your education beyond college took a back seat. I know that you look down from heaven and think, “this is the young lady who would tell us there was no school.” I hope I made you proud. I miss you each and every day. Je t’aime toujours mon papa. Ta petite fille.

Table of Contents

List of Tables

Chapter I

Introduction

Concern and respect for those less fortunate was embedded in my childhood and Catholic upbringing. My father's stories of hunger and leaving home to work on farms at a very young age left a lasting impression on me and stayed with me throughout my nursing education. As a pediatric nurse practitioner, I became increasingly aware of the needs of adolescents. My personal belief is that adolescents/youth are more often in greater need of assistance in navigating life than those other periods of development, especially if they have not had what is considered a traditional childhood.

A few years ago I had an opportunity to take a trip to a pacific coast state where a large number of young people were noted to be living on the streets with backpacks and skateboards. Observing the large amount of young people on the streets piqued my attention. In addition signs in many windows announcing that bathrooms were only for paying customers sparked an interest in what prompted this type of advertisement. People who lived in the area described a "problem" with homeless individuals and their use of community resources. I began to imagine what I would do if I was without a place to wash, brush my teeth, or care for my elimination needs if I were living on the streets. The journey to a better understanding of vulnerable adolescent populations began from that encounter.

In 2010, President Obama signed into law *The Affordable Care Act* that acknowledges the need for preventative health care and health promotion for all citizens. Unfortunately, some segments of the population will continue to be at a

disadvantage for achieving optimal health. Individuals experiencing poverty and homelessness are one segment, which are disadvantaged. A subset of this population is youth/adolescent-experiencing homelessness.

Although all ages can be affected by homelessness and each developmental level is impacted differently by the consequences of homelessness, youth/adolescent homelessness has significant ramifications for a productive and secure future (Ammerman et al., 2004; Burt, 2002; Rew, 1996). Adolescence is a time of greater vulnerability during which behavior patterns are being set for adulthood. As a result of homelessness, children and youth experience greater numbers of illnesses with an increase in the severity of illness (Feldmann & Middleman, 2003; Healthy People 2012; HRSA, 2001). Mental health issues and disruption in physical, emotional, social and cognitive development for youth who experience homelessness has been reported in the literature (Hodgson, Shelton, van den Bree, & Los, 2013; Kirst, Frederick & Erickson, 2011; Whitbeck & Hoyt, 1999; Whitbeck, Johnson, Hoyt & Cauce, 2004). Some estimates imply more than six times greater risk to health than that of individuals who are not homeless (National Coalition for the Homeless [NCH], 2008, 2009a, 2009b) and are three times more likely to report moderate to severe illness (Ensign & Bell, 2004; National Center on Family Homelessness, 2011). A reported five thousand young people die on the streets due to illness or assault on a yearly basis (National Conference of State Legislatures, 2013). Attainment of a stable consistent education is also impacted by homelessness resulting in increased delinquency (Annie E. Casey Foundation, 2013b; NCH, 2008).

Homelessness in the United States remains an ongoing social issue, present at local, national, and global levels. Low income, financial and capital inequalities, policies, structural issues, and lack of affordable homes are considered to be the primary factors contributing to homelessness (NCH, 2009a, 2009c). However, in the case of youth/adolescents the primary reasons for homelessness appear to be related to disruption of family relationships. This includes abuse, gender issues, substance abuse, and change in family dynamics such as divorce or remarriage which lead to youth running away, being thrown out, or discarded (Aratani, 2009; Bearsley-Smith, Bond, Littlefield, & Thomas, 2008; Edidin, Ganim, Hunter, & Karnik, 2012; Robertson & Toro, 1999).

The exact number of youth experiencing homelessness is elusive. Factors associated with limited access to accurate estimates of youth/adolescent experiencing homelessness can be attributed to the transient and hidden nature of this sub-population, as well as the inconsistent definition of homelessness (Edidin et al., 2012; Robertson & Toro, 1999). Estimates in the area of 1.6 million (NCH, 2008) to 1.7 million (Hammer, Finkelhor, & Sedlak, 2002) adolescent/youth are reported to experience homelessness. Statistics from The National Runaway Safeline (2013) for 2012 based on slightly more than seventeen thousand calls suggest a total of 52% of the youth calling were on the street. Of the total calls, 40% of the callers were white and 72% were female. The greatest unmet need voiced by the callers was that of shelter. The National Conference of State Legislatures (2013) reports approximately 75% of the runaway populations are female.

In Rhode Island the most current statistics from The RI Kidscount Factbook (Annie E. Casey Foundation, 2013b) suggest that adolescents and youth ages 18 to 20 had a decrease of approximately 4.5% and 21 to 24 year olds had an increase of approximately 16% for utilization of services for the homeless over the past fiscal year. Since survival is foremost for these individuals, they may engage in behaviors or activities such as forging relationships with men, survival sex and stealing that are necessary for survival and are detrimental to their health and well-being (Aratani, 2009; Edidin et al., 2012; Hodgson et al., 2013; Rew, 1996; Robertson, & Toro, 1999).

Health promotion, maintenance of health and access to health care remains a significant topic of concern for the government as well as health care providers (American Academy of Pediatrics, 2008; Healthy People 2012; United States Interagency Council on Homelessness, 2012). Nurses are focused on the promotion of health especially in areas where there is increased risk of health impairment, a lack of resources to achieve health and with populations who are most vulnerable (Coles, Themessl-Huber, & Freeman, 2012). Patient preferences in regards to care must be considered when providing care to the client. In order to achieve the best care and outcomes for clients it is crucial to acknowledge their strengths and expectations regarding their health. Understanding what youth/adolescents do to maintain and achieve health is an important dimension that has received little attention especially in the female population. (Reid, Berman, & Forchuk, 2005; Rew, 2003; Rew & Horner, 2003; Bender, Thompson, McManus, Lantry, & Flynn, 2007).

Adolescents who have experienced homelessness describe a distrust of health care providers. The literature suggests that these individuals feel that they are not

heard, not respected, and are not given the opportunity to communicate their needs or wants to health care providers (Barry, Ensign, & Lippek, 2002; Ensign & Panke, 2002; Haldenby, Berman, & Forchuk, 2007; Reid et al., 2005). Possessing the knowledge and ability to care for themselves is a reported request for these clients (Ensign & Panke). Individuals who are experiencing homelessness possess strengths and abilities, which appear unethical or illegal to the general population but allow for survival in a less than optimal situation. Nurses and other health care providers need to understand how these clients care for themselves and what information is important to them in order to be able to guide these clients towards better health.

There is extensive literature describing the negative health outcomes that can occur as a result of homelessness (Barry et al., 2002; Beharry, 2012; Boivin, Roy, Haley, & Galbaude du Fort, 2005; Dorsen, 2010; Edidin et al., 2012; Ensign & Bell, 2004; Ensign & Gittelsohn, 1998; Ensign & Santelli, 1998; Feldmann & Middleman, 2003; Haldenby et al., 2007; Kidd & Davidson, 2007; Kirst et al., 2011; Nyamathi et al, 2012; Reid et al., 2005; Rew, 1996; Rew & Horner, 2003; Robertson & Toro, 1999; Tyler, 2009; Whitbeck, Chen, & Johnson, 2006) including rape, unwanted pregnancy, trauma, sexually transmitted infections, HIV, Hepatitis, drug or alcohol dependency, sleep disturbances, malnutrition, dermatological issues, respiratory infections, dental caries, and mental illness (Beharry; Boivin et al.; Edidin et al.; Ensign & Bell; Feldmann & Middleman; Haldenby et al.; Landis, Parker & Dunbar, 2009).

Minimal research has been conducted that has identified the self-care attitudes and behaviors exhibited by adolescents who were homeless (Rew, 2003; Rew &

Horner, 2003). Barriers to accessing health care have also been described by a number of authors (Ensign & Bell, 2004; Ensign & Panke, 2002; Hudson et al., 2010; Reid et al., 2005; Rew, 2003). Barriers identified by the youth/adolescent include a lack of skills necessary to access health care and the knowledge on how the health care system works. Other barriers include lack of financial resources to purchase care or insurance, a lack of transportation to a health center and a health care atmosphere that is not adolescent/youth centric. Additional barriers include individual's perception of being stigmatized, judged or treated disrespectfully due to their homeless status (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008; Ensign & Bell; Ensign & Panke; Farrow, Deisher, Brown, Kulig, & Kipke, 1992; Gerber, 1997; Haldenby et al., 2007; Hudson et al.; Klein et al., 2000; Reid et al.).

Recent literature has begun to explore the importance of obtaining an emic perspective in order to best respond to the health needs of this population. Utilization of positive development for successful navigation to adulthood is also suggested as an approach for mitigating risk with this population (Taylor-Seehafer, 2004). Exploring and building on the strengths of people who are homeless, rather than focusing solely on negative outcomes, illness or limitations has been underscored (Rew & Horner, 2003). Ensign's (2001) research also supports this view stating it is imperative for health care providers to recognize and acknowledge, "young women are the experts about their bodies, health issues and lives" (p. 79).

Homeless youth in the U.S have been identified as a medically underserved and vulnerable population (Ensign, 2004; Oliver, 2013; Rew, 2003). Despite the fact that the numbers of adolescent women who are homeless is on the rise (Annie E.

Casey Foundation, 2013a, b; Aratani, 2009; National Alliance to End Homelessness [NAEH], 2013; NCH, 2009a; NCSL, 2013; National Law Center on Homelessness & Poverty [NLCHP], 2012) "there are astonishingly few published studies of homelessness among girls and young women" (Reid et al., 2005, pg. 239). There are even fewer studies that have used narratives to explore how adolescent girls maintained their health while they were homeless. Obtaining information directly from women who experienced homelessness during their adolescence will add to the limited knowledge base.

The research questions for this study were:

- What approaches did women use to maintain their health while they experienced homelessness as adolescents?
- What resources did women use during the time they experienced homelessness in adolescence in order to meet their basic needs and to maintain their overall well-being?
- What challenges did the women encounter in meeting their health needs?
- What suggestions do these women have for nurses and other health care providers to assist in meeting the health needs of female adolescents who are homeless?

To examine the above questions, a descriptive approach to inquiry was used. Semi-structured audiotaped interviews were conducted with women who had experienced homelessness during their adolescence. The interviews were transcribed verbatim and content analysis was used to analyze the data. Nurses and other health care providers will likely encounter adolescents who are homeless. In order to deliver

better programs to address the unique needs of the female adolescent population during homelessness, research that is particularly targeted to this population is vital.

Chapter II

Review of Literature

The body of literature on people with homelessness is vast and can be found across multiple disciplines such as nursing, psychology, sociology and political science as a few examples. From a broad perspective, exploring the available research aimed at homelessness can be categorized according to age, gender, geographical area and level of development such as childhood, adult, or elder. Research within these areas is directed towards causes of homelessness, consequences of homelessness, interventions aimed at prevention, reduction of risk, and treatment. Additional literature evaluates programs and policies with recommendations for the elimination of homelessness.

Although there is a good amount of literature from the United States that addresses the issue of homelessness, an even greater volume originates from Canada, Australia and England. These countries have significantly different social programs and health care delivery systems compared to the United States. For the purpose of this study, the literature review focused on the body of literature related to homelessness in the adolescent population in the US.

Prevalence

Accurate estimates of the prevalence of homelessness in the adolescent population are difficult to determine due to a number of complex factors. Unsheltered youth try to remain unnoticed, hidden and safe. They avoid situations or places, such as shelters and community agencies that have the potential for their minor status, while without a home to be discovered. Additional reasons associated with

determining accurate estimates include the ability for these adolescents to be fluid, highly mobile, easily dispersed in the mainstream population and their move in and out of domiciles (Aratani, 2009; Barry et al., 2002; Bender et al., 2007; Dworsky & Courtney, 2009; Edidin et al., 2012; Hyde, 2005; Kidd & Davidson, 2007; Lee, Tyler, & Wright, 2010; Martinez, 2006; Mallett, Rosenthal, Myers, Milburn, & Rotheram-Borus, 2004; National Network for Youth [NN4Y], n.d.a, n.d.b; Ringwalt, Greene, Robertson, & McPheeters, 1998; Robert, Pauzé, & Fournier, 2005; Sanchez, Waller & Greene, 2006; Washington, 2011; Whitbeck, & Hoyt, 1999; Whitbeck et al., 2004). As a result, agencies charged with tracking numbers of individuals who experience homelessness are not able to include those who are not using services, thus leading to an underrepresented estimate of unsheltered individuals. Studies intended at understanding the implications of adolescents experiencing homelessness are frequently aimed at targeted cities and may not generalize to all populations especially in urban areas.

The 2011 United States Census reports a total population of approximately 311 million adolescents living in the United States. Of this 311 million the largest subpopulation is adolescents ages 20 to 24, which is estimated at 22 million followed by ages 15 to 19 estimated at slightly fewer than 22 million (US Census Bureau, 2010). Healthy People 2020 estimate that adolescents between the ages of 10 to 24 comprise 21% of the United States population (Healthy People, 2012). Prevailing estimates of youths who experience homelessness range from 1.6 to 2 million children (Molino, 2007; NAEH, 2013; NCFH, 2009; NCH, 2008; National Runaway Safeline, 2013). Of this population an estimated 6 to 40% report being lesbian, gay, transexual,

or bisexual [LGTB] (Cochran, Stewart, Ginzler, & Cauce, 2002; Corliss, Goodenow, Nichols, & Austin, 2011; NAEH, 2013; Whitbeck, et al., 2004). In addition, aproximately 6 to 22% of young women report being pregnant (Feldmann & Middleman, 2003; NN4Y, nd, b; NCH, 2008; Thompson, Bender, Lewis, & Watkins, 2008). The Center for American Progress suggests in the youth homeless population LGTB population is the largest group with a greater number of individuals who are male (Hein, 2011). Females account for the largest population of runaway and homelessness at aproximately 75% (NCSL, 2013). The US Department of Health and Human Sevices [DHHS] (2010) reports an estimated 2-3 million people in the United States experience one night of homelessness with an estimated 800,000 people homeless on any given night. An increase in homelessness of aproximately 11% nationally has been noted from 2007 until 2012 [DHHS], 2010). The National Alliance to End Homelessness [NAEH] (2012) reports an increase of approximately 3% of homeless families during the period of 2008 to 2009 with approximately 380,000 youth under the age of 18 having experienced homelessness. For the period of 2009 to 2011 the NAEH reported approximately 21 out of 10,000 individuals were homeless. The United States Department of Housing and Urban Development [HUD] reports approximately 150,000 unaccompanied single young adults ages 18 to 24 that are homeless. Over the course of a year it is estimated that more than 550,000 youth to age 24 experience homelessness lasting greater than one week and approximately 50,000 will sleep on the street (NAEH, 2013). Point in Time, estimates conducted through the HUD Continuum of Care Homeless Assistance Programs, reports approximately 6,600 unaccompanied Youth under the age of 18 as being homeless

(HUD, 2012). A delineation of youth under the age of 25 is not considered as part of this report.

The United States Department of Education is required to provide annual data on the McKinney-Vento Education Assistance Improvement Act of 2001. For 2010 to 2011, more than one million children were reported to have experienced homelessness during the academic year (National Center for Homeless Education, 2013).

Statistics reported by The Rhode Island Coalition for the Homeless based on those who accessed available shelters indicated an increase of 484 people unsheltered since 2007 to 2011. A total of 60% of the population were single adults and 40% were families (RI Coalition for the Homeless [RICH], n.d.). The Point-in-Time Count for the state of Rhode Island in 2012 indicates that many children are living in extreme poverty with an increase of about 17% for children experiencing homelessness and about a 12.6% increase in families experiencing homelessness (O'Neill, 2013). Unfortunately these statistics from all of the various agencies do not provide a comprehensive picture since the data are gathered from shelters that do not take into account those individuals who may be homeless and not using available services. This is especially true of homelessness in rural areas.

The Conference on Mayors report (2012) for the city of Providence did not report statistics for unaccompanied youth. However the report does suggest an expected increase in unaccompanied individuals for the upcoming year. According to the RI Kids Count Fact Book (Annie E. Casey Foundation, 2013b), one shelter in Rhode Island reported an increase of unaccompanied youth accessing basic services as

well as using adult emergency shelters for 2011. The 2013 RI Kids Count Fact Book reports an increase in children who are living in single-parent families and in poverty.

Due to the "hidden" nature of adolescents all statistics and reported numbers for this population may be greatly underrepresented. According to the NAEH (2011, 2013), which examined the State of Homelessness in 35% of communities, reported that homeless youth did not exist in their communities. However, estimates of approximately 50,000 youth are on the "streets" living in areas not suitable for habitation. Furthermore these estimates are considered to be expanding (NAEH, 2012; Son, 2002). National trends noted in the Annual Report on Homelessness in America from 2010 to 2011 indicates an increase of 5.8% of poor single-person households and a 9.4% increase in poor households living doubled up. Since the age parameter for a single adult is not mentioned, this figure may include individuals who are ages 18 to 25.

Public agencies that provide services to individuals who experience homelessness are given the task of keeping count of the numbers. Points in Time counts are generally done once a year. Sponsored by HUD, continuum of care programs are charged with counting individuals who are present in shelters on a given selected date. Every other year, unsheltered individuals are also counted. Although the counts are considered to be an estimate of the numbers of homeless individuals, many people can be missed especially if they are not using services (U.S. Interagency Council on Homelessness [USICH], 2012).

Adolescents who are homeless are included in these statistics and are often grouped under the heading of children. In a report to the Office of the President and

Congress (2010) from the United States Interagency Council on Homelessness [USICH], estimates of homeless youth are significantly underreported since unaccompanied youth are not connected to shelters and assistive agencies. In response to the issue of homlessness, the federal government put forth a plan called Opening Doors: Federal Strategic Plan to Prevent and End Homelessness (2010). Annual updates suggest some movement towards decreasing homelessness. However the current report suggests the data for children experiencing homlessness has not changed significantly. An ammendment to the strategic plan in 2012 includes strategies to improve accessing comprehensive statistics on the scope of youth homessness as well as exploring evidence based practices to respond to the issue of youth homelessness (USICH, 2012).

Definition of Adolescents/Youth

Additional factors contributing to the difficulty gathering demographic data is related to the various descriptors used to define adolescent/youth as well as homelessness. These terms are not well defined and vary across studies. Age parameters for youth vary depending on the source used to define adolescent or youth. Some of the terms used to describe adolescents or youths experiencing homelessness include unaccompanied youth, runaways, throwaway/castaways, pushed-out, and street children. These terms vary in their definition and age parameters and may not accurately describe the population of youth who remain unsheltered (Aratani, 2009; Edidin et al., 2011; Farrow et al., 1992; Hagedorn & Ekegren, 2002; Son, 2002; Robertson & Toro, 1999; Toro, Lesperance, & Braciszewski, 2011; Washington, 2011).

Age parameters used to describe the period of adolescence and youth overlap and vary depending on the text or the resource that is used. Adolescence, as a developmental level, is at times divided into sub levels. Often considered to be the transition stage between childhood and adulthood, there is no consensus on a defined age parameter, which is adolescence. In the United States the ages of 10 to 19 are generally accepted as the working definition for adolescence with an extension of 20 to 24 as youth or young adult (American Psychological Association [APA], 2002; Healthy People, 2012; Homeless Emergency Assistance and Rapid Transition to Housing: Defining ‘‘Homeless” [HEARTH], 2011; World Health Organization [WHO], 2012). National Runaway Safeline (2013) uses up to age 21 as describing youth. Recent changes in the Homeless Emergency and Rapid Transition to Housing Act has expanded the definition of youth to include individuals up to age 24 (HEARTH).

Some sources use growth and development or achievement of economic independence as parameters for this stage (Garzon & Dunn, 2013). Additionally adolescence can be sub-divided into categories of early, middle, or late adolescence or into two categories of early and late with age parameters as well as specific developmental milestones within each category (Ammerman et al., 2004; Newman & Newman, 2012; Saewyc, 2011). For this study the terms adolescent and /youth were used interchangeably including individuals between the ages of 10 and 24.

Adolescence: A Time of Rapid Developmental Changes and Transition

Adolescence is a time of rapid developmental changes in the physical, cognitive, and social-emotional domains (Saewyc, 2011). Physical growth is marked

by the onset of puberty resulting in an ability to reproduce as well as achievement of adult physical proportions. Due to these rapid changes, adolescents often feel awkward or uncomfortable with their bodies.

The brain is continuing to develop in adolescence, which affect their decision-making and problem solving abilities. Newer research suggests that higher cognitive functioning at the pre-frontal cortex may not be fully mature until the mid-twenties (Giedd, 2008; Giedd et al., 2012). Their actions are guided more by the amygdala and less by the frontal cortex. The amygdala is responsible for instinctual reactions that include fear and aggression. The frontal cortex controls reasoning and helps us think before taking action. Based on the stage of brain development, adolescents are more likely to act on impulse, and engage in dangerous behaviors. They are less likely to pause and consider consequences of their actions and modify their behaviors that may be inappropriate or dangerous. Adolescents rely more on emotion vs. logical thinking (limbic) in decision-making. Around age 15, adolescents and adults make similar decisions when presented with a hypothetical situation. However in an actual situation adolescent rely more on emotion. Since adolescence is a time of experimentation, risk-taking is more likely to occur (Chamberlain & Johnson, 2011; Giedd, 2008; Giedd et al., 2012; DHHS, n.d.).

Although adolescence is characterized as a time of risk taking behaviors, some risk is needed to prepare the adolescent for future challenges. Unnecessary risks may lead to poor health choices, leading to chronic health conditions or death. Since higher brain functions related to planning, forming strategies, problem solving and foreseeing consequences of behavior is not fully mature until later in adolescence, support and

guidance should be considered as an important component during the child's transitions to adulthood. An adolescent who experiences homelessness without the needed support has a greater propensity for future risks and poorer health outcomes (Beharry, 2012; Boivin et al., 2005; Edidin et al., 2012; Farrow et al., 1992; Feldmann & Middleman, 2003; Haldenby et al., 2007; Hagedorn & Ekegren, 2002; Healthy People 2012; Rew, 2008).

Knowledge, skills and habits used throughout one's life are established during this period of development. Any alteration to healthy habits, unhealthy choices, and high risk will have disproportionate influence on the economic productivity and health of persons (Reyna, Chapman, Dougherty, & Confrey, 2012). Therefore, an inability or alteration in adolescents reaching their full potential will impact the future of the nation. Burt (2002) argues that investing in adolescents especially those at risk increases future prospects for the individual as well as economic forecasts for the larger society. Adolescents experiencing homelessness are a population at risk and without interventions to support the "normal" developmental processes.

As adolescents are moving toward increasing independence, they are struggling with developing their sense of identity. Trying on new roles and making commitments to defined sets of values and goals is typical in this stage of development. On the other side of the spectrum is not being able to achieve identity, which can lead to psychosocial issues (Newman & Newman, 2012).

Newman and Newman (2012) identified two stages of adolescence as early (12 to 18) and late (18 to 24). Early adolescence is described as focusing on having group identity versus feeling a sense of alienation. Developing one's identity begins with

aligning with group identity. Questions that can lead to internal conflicts include: "Who am I in relation to the group?" "Does membership in this group fit or not fit with my values, needs, or goals?" A positive resolution to this developmental crisis occurs when adolescents are able to discover one or more groups that meet their need to be connected, to belong and to express their "social selves" (Newman & Newman). Successful resolution of group identity leads to consideration of individual identity. In light of the many challenges adolescents face, homelessness has the potential for interfering with identity formation.

Additional considerations in early adolescence include romantic and sexual relationships including dating, first intercourse, and early discovery of sexual orientation. For some adolescents the discovery of their gender identity is a reason for family discord and expulsion from the home. A disproportionate number of lesbian, gay, transsexual, and bisexual are noted in the adolescent homeless population with a greater level of negative outcomes related to risk and violence (Abramovich, 2012; Rew, 1996; Rew, Whittaker, Taylor-Seehafer & Smith, 2005; Van Leeuwen et al., 2005; Whitbeck et al., 2004).

Later adolescence is concerned with autonomy, career choice, and establishing an internal compass for morality and gender identity. Several studies point out that in order to survive, the use of survival sex, especially in the female and gay population is used to meet their basic needs of food, shelter, and protection as well as an opportunity to earn money (Greene, Ennett, & Ringwalt, 1997; Ray, 2006; Rew et al., 2005; Rice et al, 2013; Tyler & Johnson, 2006; Whitbeck et al., 2004). As a result, the first sexual

encounter for some adolescents experiencing homelessness may be that of rape (Ensign & Bell, 2004; Coates & McKenzie-Mohr, 2010; Whitbeck et al.).

Transitioning through the stages of adolescence allows for development into a healthy functioning adult. Disruption, as in the experiences and consequences of homelessness may impede the individual's ability to navigate through the stage of adolescence with subsequent bearing on adult functioning (Ammerman et al., 2004)

Homelessness Defined

There is no one definition of homelessness in the literature. At the federal level, definitions of homelessness may vary somewhat from agency to agency, but overall the prevalent theme in the definition is an individual who is without a fixed, regular, and adequate nighttime residence or is living in a place not meant for human habitation. Legal definitions of homelessness are provided through the McKinney-Vento Act and through federal agencies primarily that of HUD. Homelessness refers to individuals who lack a fixed, regular, and adequate nighttime residence and includes:

> (i) Children and youth who are sharing the housing of other persons due to the loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;
>
> (ii) Children and youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings.
>
> (iii) Children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations or similar settings (National Health Care for the Homeless Council, n.d.; Legal Information Institute [LII], n.d.)

Adding to the mix is from the perspective of the population themselves since their perception of homelessness does not fit the definition and therefore those individuals may not identity with the term of homeless. How long an individual is homeless also has an impact on the reporting estimates for individual's experiencing homelessness. No consistent time limit is described in the definition of homelessness. Time can be as short as hours, days, or longer. The period of time can be intermittent or the individual remains lost to streets or experiences death (Edidin et al., 2012, Hodgson et al., 2013). For many youth, the time without shelter is short. Youth either return home often temporarily, go into foster care or to a transitional youth facility. For others the period of time is transient. For the purpose of this study the length of time for homelessness is defined as 24 hours or longer.

In a longitudinal study by Milburn et al. (2007), the rate and timing of youth who experienced homelessness as a result of running away from home and the length of time away from home in a population of youth in Los Angeles, California, and Melbourne, Australia were examined. The findings suggest that youth who become homeless generally returned home and remained at home within two years. Sanchez et al. (2006) suggest that youth who runaway typically return home within a one to two-month period and their experience is different from those who remain unsheltered.

Who Runs

Reasons for leaving home are variable and complex. Although economics has a role in homelessness, the greatest predictable risk for youth homelessness arises from dysfunctional family functioning (Chamberlain & Johnson, 2011; Collins & Barker, 2009; Ensign & Bell, 2004; Finfgeld-Connett, 2010; Farrow et al., 1992;

Haldenby et al., 2007; Martijn, & Sharpe, 2006; Reid et al., 2005; Rew, 2003; Rew, Taylor-Seehafer, Thomas & Yockey, 2001; Sanchez et al., 2006; Tyler, 2006; Tyler, Hagewen, & Melander, 2011; Tyler & Schmitz, 2013). Van den Bree et al. (2009) in a longitudinal population based study, examined relationships between risk factors typically noted in adolescence with reported experiences of homelessness in two separate time frames. Findings from this study supported the most significant risk factors that independently predicted homelessness as being a troubled family background, issues with school adjustment, and experiences of victimization. These risk factors support the findings from other studies suggesting dysfunctional family systems in which exposure to conflict, violence and abuse are key determinants for youth running or being expelled from home (Chamberlain & Johnson; Hickler & Auerswald, 2009; Hyde, 2005; Mallett, Rosenthal, & Keys, 2005; Oliveira & Burke, 2009; Reid et al.; Sanchez et al.; Tyler et al., 2011). Other findings include changes in family dynamics such as the introduction of a new domestic partner or remarriage and conflicts related to differing opinions in personal lifestyle choices (Hyde; Mallett et al.). Sexual or physical abuse is another reason often cited as the impetus for leaving home (Coates & McKenzie-Mohr, 2010; Johnson, Rew, Kouzekanani, 2006; Mallett et al.; Tyler & Cauce, 2002). Whitbeck, Hoyt and Ackely (1997) examined the perspectives of adolescent runaways and their parent(s) as compared to perspectives of non-runaway adolescents and their parent(s). Findings of this study suggest that lack of parental warmth, support and monitoring, as well as higher level of perceived rejection was associated as a reason for leaving home. A study looking at demographic profiles of runaway youth supported findings from previous studies that implicate

disrupted family functioning and family structure as a strong predictor, but also noted geographic differences (Sanchez et al., 2006). Youth in the South were least likely to run away followed by the Midwest and Northeast with Western youth most likely to run away. Implications for these findings were not explained but the authors suggested futher evaluation to examine these results.

In some cases, youth were forced from their homes or abandoned due to family conflict related to sexual orientation, drug abuse (Greene et al., 1997; Hein, 2011; Hyde, 2005; Tyler, 2006) or financial constraints that led to loss of domicile (NAEH, 2011; NCH, 2009). Aratani (2009) describes factors that contribute to homelessness among unaccompanied youth as being mental illness, substance abuse and lack of affordable housing. Lack of affordable housing, lack of life skills, and adult support are associated with homelessness in youth, especially those who age out of the foster care system (Dworsky & Courtney, 2009; Fowler, Toro, & Miles, 2009; Perez & Romo, 2011; Robert et al., 2005; Yen, Hammond, & Kushel, 2009). Chamberlain and Johnson (2011) suggest that the path of homelessness lasts longer due to the formation of relationships with others experiencing homelessness as well as becoming integrated into the culture of homelessness. As a result, exiting homelessness becomes more difficult. Similar findings from other studies suggest that once on the street these individuals develop “street families” which can also affect exiting from homelessness (Kidd & Davidson, 2007; Hickler & Auerswald, 2009; Oliveira & Burke, 2009).

In a study sponsored by the Casey Institute, individuals who had been in state sponsored foster care were more likely to experience homelessness and for longer periods of time after leaving state care (White et al., 2011). Zoltnick (2009) suggests a

strong link between foster care and homelessness with 15 to 22% of youth experiencing homelessness within a year of aging out of foster care. In an article in *Family Court Review*, Krinsky (2010) discusses that in American society, financial independence is most often not achieved until aproximately age 26. Therefore it is not surprising that youth who age out of foster care join the ranks of homeless, incarcerated or unemployed due to the lack of education, family support and needed social skills to navigate life.

Additional pathways to homelessness include running from foster care due to the desire to reconnect with family of origin or due to environments that are not tolerable (Hickler & Auerswald, 2009; Nesmith, 2006; Perez & Romo, 2011; Robertson & Toro, 1999; Tyler, 2006). African American youth who were experiencing homelessness in San Francisco reported failure of social services as a consequence of their homelessness; although they frequently maintained kinship ties with family members while on the streets (Hickler & Auerswald).

Culture of Homelessness

Challenges related to experiencing homelessness as well as the ability to survive has been reported in the literature. Some of the literature suggests that survival is linked to the culture in which the individual is living, as well as internal and external strengths. The experience of homelessness is not uniform. Perception and meaning of homelessness is related to the individual's experiences, gender, ethnicity, age as well as other factors. Culture implies a shared belief system, norms, values and social structure. *The American Heritage New Dictionary of Cultural Literacy online* (2013) defines culture as "The sum of attitudes, customs, and beliefs that distinguishes one

group of people from another. Culture is transmitted, through language, material objects, ritual, institutions, and art, from one generation to the next".

Homeless adolescents belong to a unique culture that shares specific dress, attitudes, beliefs, and language (Barry et al., 2002; Ensign & Panke, 2002; Oliveira & Burke, 2009). Culture is specific to geographical areas and findings may not be generalized to other geographical areas. Females experiencing homelessness share a way of life that involves gender specific issues. Females are at greater risk for violence, sexual exploitation, pregnancy, as well as a greater need for health care, safety needs and coping with experiences of living (Ensign & Panke). Several studies have attempted to describe the culture of adolescents who experience homelessness (Hickler & Auerswald, 2009; Oliveira & Burke). However a minimal amount of literature explores the culture of adolescent females who are homeless. Characteristics of this "culture" are similar across studies and relate to the risks of homelessness and non-traditional strategies used in daily living, but also indicate positive behaviors and supports that allow for survival. Peer support, connection to a "street family," and "non-homeless friends" (Bender, Ferguson, Thompson, Komlo, & Pollio, 2010; Ferguson, Bender, Thompson, Xie & Pollio; 2011) are examples of supports necessary to survival.

Consequences of Homelessness for Adolescents

The impact of experiencing homelessness is significant to a population in which development of cognitive, psychosocial, and physical growth is a major focus. Homelessness leads to disruption of development, health, emotional and social well being resulting in the risk for loss of future potential. As a developmental stage,

adolescence has been noted to be a time of growth physically, emotionally, and cognitively especially with decision-making ability and future planning.

Adolescents without the needed social supports become highly vulnerable due to perceptions that exist regarding the age at which a child can care for him or herself. Homelessness adds to the vulnerability of these children. In order to survive, they will become involved with high-risk activities to meet their basic needs. As a result of high-risk behaviors, consequences of these behaviors affect the child's physical and emotional health. Some of the issues affecting physical health include lack of adequate nutrition (Ashiabi & O'Neal, 2008; Antoniades & Tarasuk, 1998; Dachner & Tarasuk, 2002; Tarasuk, Dachner & Li, 2005; Whitbeck et al., 2005; Widome, Neumark-Sztainer, Hannan, Haines, & Story, 2009), sexually transmitted infections including HIV and AIDS and chlamydia (Beech, Myers, Beech, & Kernick, 2003; Edidin et al., 2012; Feldmann & Middleman, 2003; Halcon & Lifson, 2004; Henning, Alice, Sanci & Dunning, 2007; Rew, Chambers & Kulkarni, 2002; Rew & Horner, 2003; Rew et al., 2005; Richardson et al., 2003), pregnancy (Greene, & Ringwalt, 1998; Haley, Roy, Leclerc, Boudreau, & Boivin, 2004; Smid, Bourgois &Auerswald, 2010; Thompson et al., 2008), substance abuse (Chen et al., 2004; Feng, DeBeck, Kerr, Mathias, Montaner, & Wood, 2012; Greene et al., 1997; Hickler & Auerswald, 2009; Mc Morris, Tyler, Whitbeck, & Hoyt, 2002; Mallett et al., 2005; Oliveira & Burke, 2009; Slesnick & Meade, 2001), mental illness (Hodgson et al., 2013; Rhode, Noell, Ochs, & Seeley, 2001; Whitbeck et al., 2004; Tyler & Melander, 2010), suicide, (Boivin et al., 2005; Cleverley & Kidd, 2011; Kidd & Carroll, 2007; Rew, Taylor-Seehafer, & Fitzgerald, 2001; Yoder, Hoyt & Whitbeck, 1998) trauma (Gwadz, Nish, Leonard, &

Strauss, 2007; McManus & Thompson, 2008) and violence (Heerde & Hemphill, 2013; Kipke, Simon, Montgomery, Unger & Iversen, 1997; Oliveira & Burke, 2009).

Food Security

Adolescence is a time of rapid physical growth in which adequate nutrition is needed in order to meet the body's needs. In the general population adolescents are noted to have poor eating habits and often lack the needed vitamins, iron, magnesium, zinc, and calcium for proper growth (Saewyc, 2011). Adolescents experiencing homelessness, may be overweight due to the availability of foods that come from fast food places, soup kitchens, or food banks where the use of canned or processed non-perishable foods are offered (Franklin et al., 2012; Richards, Smith, & Eggert, 2013). Lack of proper nutrition has the potential to lead to poor health outcomes including the inability for wounds to heal and decreased immunity. Additionally, the nutritional soundness of affordable foods are often assoicated with high amounts of salt and fats (Beharry, 2012; Dachner, & Tarasuk, 2013).

A lack of money to purchase food and non-participation in food assistance programs is notable in this population. Although governmental assistance in food stamps known as Supplemental Nutrition Assistance Program (SNAP) is available, certain conditions must be met. Some form of documentation that proves identity such as a drivers license, school identification card or birth certificate must be presented to obtain food stamps. Some programs have started computer access for adolescents who are homeless to upload their personal documents such as birth certificates, driver's license number and social security number for free. Proof of income is not always needed. However in some states application to work or training programs must occur

in order to keep benefits (United States Department of Agriculture, 2013; MassLegalHelp, 2013). Adolescents who experience homelessness frequently do not have access to such documents and are therefore often unemployed or working under the table.

Homelessness does not allow for regularly scheduled meals. Shelters, churches, food kitchens, and schools may offer some opportunities for a hot meal. Food banks typically have canned or boxed food. In many cases adolescents who are not in school are not able to access food assistance. In addition shelters and environments in which exposure to adults is avoided impacts this source of food assistance. Whitbeck, Chen and Johnson (2006) examined the factors associated with food insecurity in homeless and runaway adoloescents. Their longitudinal study regarding food security comprised of interviews with 428 individuals with a mean age of 17.4 years. Based on their findings an estimate of more than one-third of the sample had experienced food insecurity in the previous 30 days. Additional findings which support concerns of risk taking behaviors leading to further health and emotional issues were noted with unsheltered adolescents who engaged in risky behaviors including panhandling, shop-lifting, theft, dumpster diving, and survival sex in order to procure resources to obtain food with a range of 29.44 to 35.83% reported going hungry.

Two other studies examining food aquistion and food insecurity took place in Canada. Antoniades and Tarasuk (1998) used a survey to examine the experiences of a group of 88 youth who were experiencing homelessness in Toronto. Results indicated that experiences of hunger were associated with the type of accomodations the

individuals were living in. Participants who were associated with a shelter or rooming house experienced less hunger compared to those who were on the street. Concern as to where to obtain food and having enough food was reported in two-thirds of the sample. Although measurement of body mass index did not show a significant relationship with hunger, assessment of nutritional soundness was not included as a component of the study.

Dachner and Tarasuk (2002) used ethnographic methods including semi-stuctured interviews to examine food insecurity and daily survival of life of homeless youth on the streets of Toronto. Food aquisition was a daily concern for these youth and the constraints of their situation greatly impacted the ability to purchase food and the quality of food that was affordable. Food in this situation was a "precious commodity" that was carefully guarded and shared.

Mental Health and Social Issues

A significant amount of literature reports an association of risk for mental health issues and homelessness. Mental health, exposure to violence or trauma is an area of concern and risk for this population. Risks such as exposure to violence and vicitmization have the potential of leading to homelessness. Hodgson et al. (2013) conducted a systematic review of the psychopathology for "young people" who experienced homelessness. "Psychopathology" was frequently present prior to being homeless. However the experiences of homelessness exacerbated the psychopathology.

Homeless youth are more likely to experience physical and/or sexual abuse than those who are not homeless either as a witness or as a victim (Aratani, 2009;

Edidin et al., 2012; Kipke et al., 1997; Mallett et al., 2005; Whitbeck et al., 2004). Exposure and victimization related to violence continues during the periods of homelessness (Aratani, 2009; Rew, 2008; Rew, 1996; Reid et al., 2005; Stewart, Steinman, Cauce, Cochron, Whitbeck, & Hoyt, 2004; Tyler, Gervais, & Davidson, 2013). Rates of exposure to violence was found to be somewhat equal between males and females in a study by Kipke et al. (1997). In this study, exposure to violence in a sample of 432 homeless youths in Los Angeles California was explored and rates of exposure were noted to be high. Sexual assault and fear of being hurt by being stabbed, shot or beaten were found to be more associated with females than males. (HRSA, 2010). However both genders reported exposure to violence at fairly equal rates. Individuals who are lesbian, transgender, gay or bisexual [LTGB] are at greater risk for vicitmization as compared to individuals who are heterosexual. Since it is estimated nearly half of the homeless adolescent population is LGTB, a greater proportion of this population individuals are at risk for victimization (Aratani, 2009; Cochran et al., 2002; Hein, 2011; Tyler, 2008; Whitbeck, Chen, Hoyt, Tyler, & Johnson, 2004).

Exposure and victimization as well as stressors of experiencing homelessness is highly associated with substance abuse including alcohol, marijuana, or injectable drugs and risk of suicide. In some instances substance abuse is a cause of expulsion or volunatarily leaving home. However stessors of living on the street and trying to survive is often the catalyst for the onset of substance use. A significant subset of literature related to substance abuse and homlessness is dedicated to this problem in the context of adolescence. Studies examining the issue of substance abuse,

consequences of substance abuse, and interventions to alleviate or minimize the risk of substance abuse are present (Bousman et al., 2005; Feng et al., 2013; Gomez, Thompson & Barczyk, 2010; McMorris et al., 2002; Nyamathi et al., 2010; Slesnick & Meade, 2001).

Suicide rates are notably higher in adolescents experiencing homelessness (Boivin et al., 2005; Ganz & Sher, 2012; Rew et al., 2001; Robertson & Toro, 1999; Thompson et al., 2012). In a narrative study by Kidd and Kral (2002), it was suggested that adolescents engaging with trading sex and prostitution had a high degree of suicide attempts with approximately three-quarters of the sample reporting they had attemped to commit suicide. Additional reasons for high suicide rates in the adolescent population expeiencing homelessness is associated with underlying mental illness exacerbated by the situation.

Experiences of abuse and exposure to violence leads to increased distrust of adults thus distrust of agencies that are managed by adults and decreased use of available mental health services (Collins & Barker, 2009; Kozloff et al., 2013; Rew, 1996, 2003).

Unaccompanied youth are at greater risk for mental health problems such as post-traumatic stress disorder (PTSD) and conduct disorders (Bender et al., 2010; Bender et al., 2013). Whitbeck et al. (2004) examined the development of symptoms of mental illness in a cohort of homeless adolescents from several midwestern cities compared with a cohort of housed adolescents from the same area. Findings indicated homeless adolescent females were five times more likely to have symptomology consistent with post-traumatic stress disorder [PTSD]. Alumi of foster care who

experinced homelessness were noted to have higher rates of individuals with symptoms of PTSD (White et al., 2011). Gender differences were noted in rates and symptomatology of PTSD as well as self-harm and suicide attempts for adolescents expeiencing homlessness. Females were found to have higher rates of PTSD as well as greater self-harming behaviors and attempted suicides as compared to males (Gwadz, 2007; Moskowitz, Stein & Lightfoot, 2012). Other prevailing disorders reported by a number of authors include depression, and conduct disorders. (Edidin et al., 2012; Hoddgson et al., 2013; Slesnick & Prestopnik, 2008; Stewart et al., 2004).

Association of drug use and other risky sexual behaviors such as “pimping”, survival sex, internet prowling for sexual encounters, and sexual interactions while under the influence of a substance add additional mental and physical health concerns (Chen, Tyler, Whitbeck & Hoyt, 2004; Ensign & Panke, 2002; Farrow et al., 1992; Greene & Ringwalt, 1998; Tyler & Melander, 2010; Tyler & Schmitz, 2013; Tyler, Whitbeck, Hoyt, & Cauce, 2004). The use of injectable drugs as well as risky sexual behaviors are corrolated with the development of potentially devastating diseases such HIV/AIDS and Hepatitis (Burgois, Prince & Moss, 2004; Hickler & Auerswald, 2009; Tenner, Trevithick, Wagner & Burch, 1998). In addition to the more significant health risks of HIV/AIDS and hepatitis, other sexually transmitted infections and pregnancy are also of concern (Ensign, 2000; Greene & Ringwalt, 1998; Kral, Molmar, Booth, & Watters, 1997; Rew, Foulaadi, & Yockey, 2002; Smid et al., 2010; Thompson et al., 2008).

High risk behaviors and mechanisms for supporting these behaviors contribute to the higher percentages of youth finding themselves engaging in deliquent behaviors.

Stealing, selling or transporting drugs, prostitution, robbery are some examples. The lack of resources and length of time on the street may also increase the prospect of being involved in a violent crime (Aratani, 2009; Baron, 2013; Coates & McKenzie-Mohr, 2010; Hickler & Auerswald, 2009; Hein, 2011; Oliveira & Burke, 2009).

Consequences of experiencing homelessness affect not only the physical and emotional health of adolescents, but also impact educational opportunities. Due to the instability and transient nature of homelessness, completion of school and continuation of higher education or technical school is often not accomplished. Once again, contributing to the loss of future (Aratani, 2009; Edidin et al., 2012; Rafferty, Shinn & Weitzman, 2004; Stewart et al., 2004).

Physical Health

Women experiencing homelessness have been identified as being highly vulnerable and a "sub-culture" who are medically underserved (Ensign & Panke, 2002; Haldenby et al., 2007). Adolescent females are at greater risk for being victimized and for experiencing health disparities (Haldenby et al.; Hoyt, Ryan, & Cauce, 1999; Lee et al., 2010). Adolescents experiencing homelessness have the same health care needs as those who are housed. However, due to the consequences of homelessness, and a lack of access of physical care, health promotion and disease prevention, many adolescents will potentially have health problems that are more problematic and difficult to treat (Dawson & Jackson, 2013; Klein et al., 2000, NHCHC, n.d.). Additionally, the lack of food and shelter also have an impact on health resulting in malnutrition, sleep deprivation and conditions resulting from exposure to wet, cold, or heat (Beharry, 2012; Reid et al., 2005; Rew, 1996). In

addition to the typical preventable issues, Rew (1996) outlined health risks along with the contextual factors for adolescents experiencing homelessness into four domains: physical, psycholgical, social and spiritual. Additional consideration was suggested for culturally and holistic care of the adolescent when planning health services.

Minimal literature was found exploring spirituality and in this case is related more to hope, care, and meaning rather than a deity or organized religion. It is an area that has minimal literature however it is at times discussed briefly in context to other research questions or concepts especially in regards to resilience and strenghts (Bender et al., 2007; Williams & Lindsey, 2005).

Adolescent health care includes immunizations, screenings, and assessments. Depending on the age when homelessness occurs, protection for certain diseases through immunizations, as well as screenings for preventable health issues will be impacted. Protection through immunization is primarily for meningitis, tetnus, diptheria, acellular pertussis (Tdap), hepatitis A, and human papillomavirus vaccine (HPV). Screenings and risk assessments generally done during adolescence include blood pressure screening, hemoglobin and heatocrit levels, dylipidemia screening, sexually transmitted infections (STI) screening, hearing and vision screenings, drug and alcohol assessments, as well as assessment of the behavior and psychosocial aspects (AAP, n.d.; US Preventative Services Task Force, n.d.).

Strategies Used by Adolescents Experiencing Homelessness

Survival is by far the most important need for the individual expeiencing homlessness (Bender et al., 2007; Ferguson et al., 2011; Rew, 2003; Robertson &

Toro, 1999). In order to endure life while homeless, individuals often develop strategies that may not be generally acceptable or legal.

Several studies have explored how adolescents survive the experience of homelessness. However, there is minimal literature which focuses specifically on female adolescents and survival. Survival strategies used by this population can be described as generally not pro-social, but may border on criminal behavior. However, findings from several studies examining survival and strengths indicate a high level of resourcefulness in meeting their physical and emotional needs while maintianing forward movement (Kidd & Davidson, 2007; Rew, 2003; Rew & Horner, 2003; Rew et al., 2001; Robertson & Toro, 1999). Bender et al. (2007) explored strengths in a population of homeless adolescents and described personal strengths or attributes with a corresponding skill set which allowed for survival. Key attributes included responsibility for self, aspirations and goals, maturity, positive attitude, and trust. These findings suggest that survival is dependent on an individual's ability to develop street smarts such as learning the "rules." discerning who to trust, and adapting to the "culture" of the streets. However external resources such as peer supports and societal resources were often identified by the participants prior to identification of the individual's internal strengths. In some cases adolescents experiencing homelessness changed their behaviors and successfully exited homelessness as a result of increased maturity, observing the demise of others, or as a result of being responsible for another person or dog (Rew & Horner, 2003).

Knowledge of resources and peer networking are key components of strength. Those who perceive themselves as resilient,were less likely to engage in risky

behaviors regardless of their disconnection from their nuclear family (Rew et al., 2001). Once basic needs were met, attention to health, wellness, health promotion and disease prevention could be addressed.

Barriers to Accessing Health Care

Experiencing homelessness leads to a disruption in the attainment of health care. Homeless adolescents typically seek health care when absolutly necessary. Consequently, delay in accessing care may lead to a chronic condition or disability. Limitations in accessing health care is a recurrent theme in the literature. Factors such as lack of transportation, health insurance, monies to pay for services, inability to provide consent due to age, a lack of knowledge regarding how the health care system functions, and lack of knowledge regarding health promotion, or disease prevention such as adequate immunization affects the adolescents ability to access adequate health care (Dawson & Jackson, 2013; Doroshenko, Hatchette, Halperin, MacDonald & Graham, 2012; Hudson et al., 2010). Additional factors include fear of discovery, health care providers being uncaring and unempathic as well as perceived feelings of discrimination and stigmatization (Darkwah et al., 2012; Ensign & Bell, 2004; Ensign & Panke, 2002; Gerber, 1997; Oliver, 2013; Reid et al., 2005).

There are only a few studies that have examined adolescents' experiences during homelessness regarding health and strategies they used to take care their basic health needs (Ensign & Panke, 2002; Reid et al., 2005; Rew, 2003). In the area of women's health, issues related to reproductive health are highly explored. However an emic perspective of how adolescent females cared for themselves, how they accessed information or sought advice to maintain their health is lacking.

Summary

Recommendations from various studies suggest approaching holistic care of the adolescent experiencing homelessness from a positive strenghts approach (Bender et al., 2007; Lindsey, Kurtz, Jarvis, Williams & Nackerud, 2000; Rew, 2008; Rew & Horner, 2003). Focusing on the resourcefullness and current strengths of the individual builds confidence and trust between the individual and providers.

Chapter III

Methodology

The experiences of women who were homeless during their adolescence were the focus of this study. The specific research questions were:

- What approaches did women use to maintain their health while they experienced homelessness as adolescents?
- What resources did women use during the time they experienced homelessness in adolescence in order to meet their basic needs and to maintain their overall well-being?
- What challenges did the women encounter in meeting their health needs?
- What suggestions do these women have for nurses and other health care providers to assist in meeting the health needs of female adolescents who are homeless?

A qualitative descriptive design combined with semi-structured interactive interviewing was used for this study. Qualitative descriptive studies produce findings that are close to the data and seek to understand experiences of individuals (Denzin & Lincoln, 2011; Sandelowski, 2000, 2010). Recounting of personal experiences of events, which are significant to the individual, allows for the building of knowledge, which in turn informs recipients of information. Health care providers as well as society as a whole can develop a greater understanding of "what is going on" (Marecek, 2003; Marecek, Fine, & Kidder, 1997; Morse, 2011; Speziale & Carpenter, 2007). With this type of inquiry, knowledge is constructed from the rich descriptions provided by participants (Parse, 2001). Consequently recollections, insights and

understanding of events can contribute to construction of theory. Although there are a variety of methods to elicit information from participants, the research question and sample drives the best method to reach the who, what, and when of an experience (Richards & Morse, 2007; Sandelowski, 2000).

Participants and Setting

Upon approval from the University of Rhode Island Institutional Review Board (Appendix A), a purposive convenience sample was recruited for this study to explore the experiences of young adult women who were homeless when they were adolescents (unsheltered). The sample consisted of 9 women between the ages of 23 to 39 with a mean age of 28.8 years. Three of the women were above the age of 30 and the remaining women were in the range of 23 to 28 years. Selection criteria included: the ability to read and understand English, experienced homelessness for a period of time during adolescence and a willingness to participate in a 1 to 2 hour interview.

Potential research participants were recruited from a residential facility for young women in a northeastern city. The administrator of the program at this facility presented an introduction to the proposed study during group meetings and asked the women who were interested to self-identify. At that time an appointment with the researcher was scheduled for an interview.

Data Collection

Prior to data collection, an explanation of the purpose of the research study as well as the risks and benefits were discussed with each participant individually. Participants were made aware that the researcher applied for a Certificate of Confidentially (Lutz, Shelton, Robrecht, Hatton, & Beckett, 2000). Consent for

participation in the study was obtained after the participant had time to ask questions from the researcher.

Demographics

After informed consent was obtained (Appendix B), the participants were asked to complete a demographic form (Appendix C), which included their age, race/ethnicity, education, length of time they were not housed, medical and psychiatric history, and medications. Participants were asked if they had health insurance and a primary care provider. The question of race and ethnicity was changed to include only race after the first interview was completed due to the participant's confusion regarding differences between race and ethnicity.

Semi-structured Interview

For this study a semi-structured open-ended interview was used for data collection (Appendix D). An interview guide assisted this researcher to remain on target, and provide some sequencing and guidance without interfering with the flow of the participant's reflections and descriptions (Polit & Beck, 2008; Seidman, 2006). The interview questions were based on the research questions and the literature review. This type of interview allowed the participants to respond to the interview questions in their own words and at their own pace. To ensure that the interview guide contained appropriate wording that was culturally sensitive, age appropriate and non-judgmental, faculty members who have expertise with this population and the director of the program reviewed the content from the interview guide. Adjustment to the language used was not needed.

Ethical Considerations

Since women with a past history of homelessness can be considered a vulnerable group, the researcher must be very sensitive to issues of informed consent and confidentiality. In addition**,** questions related to homelessness and experiences during that period of time could potentially raise emotional reactions. Therefore the researcher limited the interview length to no more than 2 hours, allowed for flexibility in the structure of the interview, scheduled the interview in a conference room in the facility which was a "safe" and private place, and identified a referral source within the agency for management of psychological distress if that occurred, (Draucker, Martsolf & Poole, 2009; Kavanaugh & Ayres, 1998).

Allotment of at least one and one-half to two hours per interview was reserved. Interviews were audiotaped using a digital voice-recorder and participants chose a pseudonym at the onset of the interview that was used during the interview. Interviews were scheduled in the late afternoon at 1 p.m. and 3 p.m. in order to accommodate the participants' schedule of activities. Assessment of the participants' level of comfort was carefully monitored during the interviews. Process consent (Usher & Arthur, 1998) was used and participants were frequently asked if they wished to continue as well as reminding them that they could stop at any time, or take a break if needed.

A twenty-five dollar gift certificate was given to the participants at the completion of the interview in appreciation for their time and participation, which surprised them. They were extremely grateful for this gift.

Due to the sensitive nature of the study, all transcribed audiotapes, notes, consent and demographic forms were kept in a locked box. The listing of names with

an assigned pseudonym were recorded on a different piece of paper and kept separate from the rest of the study data. A code number and pseudonym identified the interviews. Pseudonyms were self-selected by the participant. The study records including the audiotapes were shared with only two additional researchers who were dissertation committee members. At the end of the research, all audiotapes will be destroyed and study materials will be kept in the researcher's office and destroyed after three years.

Sharing one's experiences can have positive or negative outcomes for the participant. However, the literature does note that participants can benefit from participating in interviews (Corbin & Morse, 2003; Hutchinson, Wilson & Wilson, 1994; Riessman, 1993). In the process of interviewing study participants have described feeling a sense of relief in expressing personal feelings and can benefit from having their experiences validated (Hutchinson et al.,; Riessman). Since researchers are co-participants in the data collection process, journaling was done by the researcher at the end of each interview to allow for personal reflection on the interview and to document any concerns or issues that occurred during the interview process.

Data Analysis

Analysis proceeded from the researcher listening to the interview tapes prior to transcription to begin the immersion process and to obtain a sense of the whole. Tapes of the interviews were then transcribed verbatim through a transcription company that specializes in all forms of transcription including medical transcription. Transcribers who handled the transcription were fully aware of the sensitivity and confidentiality of

the materials. No identifiable materials were included in the process of transcription. Any potential identifiers were removed prior to transcription. Transcripts were then read several times to allow for immersion in the data and increase familiarity with each participant.

Qualitative content analysis (QCA) was used to analyze the transcripts. Qualitative content analysis (QCA) is considered to be an excellent choice for qualitative descriptive studies and is frequently used in nursing research (Hsieh & Shannon, 2005; Sandelowski, 2000, 2010; Schilling, 2006). This method is a systematic process that is flexible with the intent of reducing large amounts of data (Schreier, 2012; Taylor & Renner, 2003). In essence the data in context was analyzed without jumping to rash conclusions.

Krippendorff (2013) defines qualitative content analysis as a "research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use" (p. 24). Qualitative content analysis does not attempt to separate the analyst from findings and seeks to "recognize meanings" as described by the participant, but also the meanings that are imbedded between the "lines." Referred to as manifest and latent meanings, analysts seek to hear what has been said (manifest) and what has not been said (latent) (Krippendorff, 2013). Graneheim and Lundman (2004) assert that the researcher should decide whether analysis should focus on what is explicitly being verbalized which is the "visible and obvious" (manifest content) and analysis of the "underlying meaning" (latent content). The authors suggest that a decision should be made on one or the other due to depth

and level of abstraction; however interpretation from both perspectives is possible (Sandelowski, 2000).

As an analytic process, qualitative content analysis has some fluidity in the approach. Several authors describe a "model" or stepwise approach when using qualitative content analysis (Graneheim & Lundman, 2004; Krippendorff, 2013; Schreier, 2012). Similar in approach, each author emphasizes a systematic approach in which the analyst examines the data, draws inferences, condenses or summarizes data, and categorizes data to identify themes and patterns emerging from the data.

For this study the conventional approach to content analysis described by Hsieh and Shannon (2005) was used. After the transcripts were read as a whole several times, the data was read carefully word for word, sentence-by-sentence. Codes were then derived by highlighting key words in the text that captured the participants' thoughts. Initial impressions by the researcher were also documented. As this detailed process continued, labels for codes began to emerge that were reflective of more than one key thought. The codes were then sorted and grouped into categories based on how the codes were related. Direct quotes were then taken from the transcribed interviews to support the categories and provide descriptions using the participants' own words.

Trustworthiness

As with any research method, attention to details of trustworthiness and validity are essential. How validity is described varies depending on which text is used. However the basic premise is to assure in some manner that the fit of the chosen methodology is consistent with the research questions and management of the data is

appropriate to the method. In addition, the researcher should be able to account for each step of the process from beginning to dissemination of findings.

Lincoln and Guba (1985) identified a number of criteria that can be used to establish trustworthiness of qualitative data and discussed activities that can be employed to address the criteria. To increase the probability that the findings were credible, prolonged engagement was used initially to establish trust in the organization. Time was spent meeting with the director of the facility and observing how the women participated in their day-to-day lives.

A peer researcher with knowledge of the process and area explored the material with the researcher looking for errors in the process, bias, omissions, non-congruency as well as any other concerns related to the findings (Polit & Beck, 2008). Peer debriefing was also utilized throughout the study to explore the process of data collection and discuss the effect of hearing painful stories on the researcher. Informal member checking occurred during the interviews. Comments made during the interviews by the participants were often reflected back to ensure accuracy or clarify any questions the researcher had.

The committee chair and this researcher independently coded the data and then met to discuss the codes until full agreement was reached. Very few differences in coding actually occurred. The two researchers then worked as a team to develop the categories. Thick description in the form of quotes from the text was used to provide descriptions of the participants' experiences during their period of homelessness. Finally an audit trail of records occurred throughout the research process. All data

including the researcher's journals was made available to the chair and members of the dissertation committee.

Attention to high researcher standards in conduct, transparency, thoughtful interpretation of data, and representation of findings was the goal for this researcher. Regardless of which framework a researcher uses to assure validity it will be how a researcher demonstrated their accountability to the data and process that will ultimately determine trustworthiness (Graneheim & Lundman, 2004).

Chapter IV Findings

The results of this study are descriptions of the experiences of women during their period (s) of homelessness. The data was collected through semi-structured interviews. The purpose of the analysis was to address the following research questions:

- What approaches did women use to maintain their health while they experienced homelessness as adolescents?
- What resources did women use during the time they experienced homelessness in adolescence in order to meet their basic needs and to maintain their overall well-being?
- What challenges did the women encounter in meeting their health needs?
- What suggestions do these women have for nurses and other health care providers to assist in meeting the health needs of female adolescents who are homeless?

The study sample was comprised of nine women who have been given fictitious names. The complete transcription of each audiotaped interview was initially treated as a whole and read several times prior to conducting manifest and latent content analysis. Nine women between the ages of 23 to 39 (mean 28.8) participated in this study. Despite efforts to obtain a diverse population, all women were Caucasian (Table 1). Typically there is quite a diverse population in this setting. However, at the time of this study, the population was more homogenous. Length of time the individual experienced homelessness, amount of time homeless, as well as where the women originally came from did have some diversity. As a result of the analytic

process, six categories were identified and two themes emerged. The categories are listed as (1) hunger; (2) staying safe, warm and rested; (3) keeping clean; (4) resourcefulness; (5) challenges encountered; (6) insights and recommendations. The two themes that emerged were (1) survival takes precedence; and (2) remaining invisible.

Discussion of Categories

It was striking to see the creativity and resourcefulness that these women used to address issues resulting from their homelessness. Although resourcefulness is one of the major categories, there are rich examples of resourcefulness that are also integrated in the other five categories.

Hunger. Accessing food was considered a priority, but access to food was not always possible. Eating three meals a day or even one meal per day could be difficult. For several of the women, getting something to eat was their greatest challenge while experiencing homelessness. One woman stated that there were times *"I went like a week without eating."* Another woman reported that she would ask for food from strangers *"like if I'm hungry I'll go and ask somebody, Can you help me with food?" . . . "Whatever I need I'll get." "I just tried finding food here and there."* Jade (age 32) and Sydney (age 26) similarly reported not having enough to eat; maintaining weight and nourishment were their greatest challenges while experiencing homelessness. Kelli (age 28) clearly became emotional when thinking about her hunger and how bad if felt to be that hungry. *"There were times I went like a week without eating." "Hunger is bad. I lost a lot of weight."* (Kelli).

Most of the women described reliance on friends for a hot meal. If they were unable to access food from friends many of the women reported that they would not eat. Reliance on friends also involved taking food from their friends' homes for use later on. One woman actually returned to their home during the day when the parent was at work to take food from her kitchen. *"A lot of time at night I would go into their food pantry and put stuff in a bag . . . I really didn't make good food choice . . . the more fattening stuff would keep me full longer"* (Sydney, age 26).

Several of the women worked as waitresses and accessed food at their employment. "*Working as a waitress . . . well, we had food you know. Eating well, that is a basic thing"* (Lita, age 26). Another woman used her welfare to buy food at fast food places.

As for selection of food the women discussed getting whatever they could. Attention to a balanced diet was not possible, however, one participant did express a desire to choose food that would keep her full for longer periods of time and would be higher in calories to maintain her weight. Another reported that if she could request food she would ask for foods such as peanut butter, bread and fruit in a can. This participant also wished that someone had taught her what types of foods to ask for that would be beneficial for someone who had limited resources.

It is important to note that these women reported not being aware of food pantries, soup kitchens, or other resources that might be available to them for food. A few suggested that even if they had known about a food pantry they may not have used this resource due to a sense of embarrassment and a desire to keep the homelessness hidden. Those who were still in school during this period of time

reported that they would not seek free hot meals since the paperwork for this benefit had to be completed by a parent. Once again, due to the fear of exposure or "someone finding out" that they were not living at home but were experiencing homelessness prevented these individuals from accessing meals at school.

Staying safe, warm, and rested. Managing personal safety was a critical concern for these women. As one participant stated, *"Um, there was nothing safe about that at all. There's definitely nothing safe*" (Sydney, age 26). *"I just didn't feel safe anywhere"* (Gabrielle, age 39). *"I felt very vulnerable"* (Lita, age 26). Strategies used to increase safety ranged from partnering with others on the streets and carrying pocketknives, pepper spray and tire irons. *"You know I had a tire iron or a screwdriver with me, it made me feel a little safer"* (Lita). Kellie stated, *"I always had a knife in my pocket. That was another thing."*

While others expressed careful selection of the surroundings, exposure to violence varied depending on the location the participant was living as well as whom the participant was with. Being homeless with someone they trusted provided a perceived sense of protection and security.

Other strategies included projecting an image that suggested no fear as verbalized by Kelli *"trying to make myself appear bigger than I was . . . I acted like I was tougher . . ."* For some women, the environment in which they were homeless was perceived as not *"violent"* or "*unsafe place,"* indicating that the community in which they were living did not have a reputation as an unsafe city. For others, the places that were quiet and isolated were frightening and felt unsafe.

> *"I tried to stay away from the quiet, like the quiet kind of scared me. I wouldn't um, I wouldn't want to be where there wasn't a lot of light or*

> *there wasn't a lot of noise because I felt like that maybe, you know, that was a bad thing."* (Sydney, age 26)

Some participants had experienced violence in the form of rape and abuse. Joy (age 31) described situations in which she had a gun and knife pulled on her as well as having been beaten.

Accessing shelter was another key priority especially during colder times of the year. *"I just remember trying to have a lot of blankets . . . and you know, our body heat on each other at night"* (Kay, age 23). Age was a barrier that the women discussed. In order to rent an apartment or even get a hotel room the individual needed to be over 18. One woman would find a man and have him rent her a room. Another woman used her skills as a graphic artist to change her age on her ID so that she could rent an apartment. The majority of women described "couch surfing" or sleeping over at a friend's home. *"I couldn't believe it came to this . . . I was sleeping in cars"* (Kay). Others slept in abandoned buildings, or in a tent outside. *"I found this sober house on Craigslist and ended up staying there for two months.…I asked someone of the street to use a cell phone* (Kay). Sydney (age 26) described:

> *". . . trying to find people her own age and I'd say, 'HI, I'd like to be your friend. Can you take me home?' Some of them had parents who were alcoholics or drug addicts and we would stay in the basement. Sometimes I had to hide in the closet so the parents wouldn't see me".*

Another participant spoke of a strategy she used especially for the cold winter months. She would pay the first month's rent and then wait to be evicted. Since it took several months for that to occur she would be sheltered for some time.

For the women who experienced homelessness as transient periods, the type of shelter would vary and could change. One woman replied, *"I always found shelter. I never just slept in the rain or anything. You just become crafty."* One woman lived on

a fishing boat for shelter. Another worked as a housekeeper for a motel so that she could benefit from a free room. In addition to friends, many of the women discussed using men to provide shelter. The same woman who discussed being crafty also described a strategy she used when she was *"sick"* of trying to find shelter and would "*conveniently fall in love*" (Joy, age 31).

> *"I would start like going out with a boy and move in with them but I really…Like I liked them but I didn't really like them-like them. So I had a place to live but it wasn't mine . . ."*

Several of the women described *"using men"* for shelter. Although it is possible that these women provided sex for shelter, it was not verbalized as such during the interviews. The majority of women reported that they were not aware of shelters especially those who were very young at the time of their initial homelessness. Those who became aware of the availability of shelters reported that they would not use them even if they had been aware of their existence due to concerns of personal safety. For the few women who were at the younger side of adolescence were fearful of being exposed and returned to their family or foster family. For these women the possibility of returning to their homes was worse than being on the street.

The majority of the women verbalized "*friends"* as a source of shelter. What is interesting to note is the façade of a "normal sleepover." Lynn (age 28) and Sarah (age 27) spoke of staying with their best friend for a period of time. Sydney (age 26) ran from her foster placement and spoke of relying on "friends" or acquaintances for shelter and resources. *"I did a lot of couch surfing to different people's houses and stuff* (Gabrielle, age 39)." Sydney also described how she would find places to stay:

> *"I had, like to find people my own age to see if maybe I could fit in somewhere . . .'Hi I'd like to be your friend. Can you take me home?'"*

Getting adequate rest and sleep was elusive for these women regardless of being sheltered. *"I don't feel like I slept enough"* (Lita, age 26). Most of the women did not report feeling rested. Reasons for this revolved around lack of comfort from sleeping in a car or at a friend's house. Some described the feeling of "*not knowing what was going to happen next"* as a cause of not getting a good night's sleep. Others described not feeling rested due to the type of work they were doing such as waitressing. For others the drug addiction behaviors impacted their sleep patterns.

Keeping clean. The women worked hard to meet their basic hygienic needs. Although the ability to shower was not a daily occurrence, oral hygiene as in brushing one's teeth was something that each woman discussed as important to them. Most of the women brushed at least once a day and a few others tried to brush several times a day. Using public bathrooms provided a place and running water to brush. For another participant a bottle of water and a toothbrush allowed her to brush anywhere as she *could spit on the ground*. When asked why brushing teeth were important, the women reported that they felt clean and it was a way to keep up outward appearances. For others, brushing their teeth was related to keeping healthy and not having to see a dentist. *"Yeah, I did shower whenever I got the chance, I did brush my teeth whenever I got the-I kept up outer appearance . . ."* (Sydney, age 26).

Most of the women spoke of relying on their "friends" to meet some of their basic needs. However the term friends were not fully explored in this study. The women did use the term friends to describe individuals they knew well, or to describe someone who they had recently met on the street. The term friend was used to describe the people who they *"hung out with and shared drugs with."* For several of

the women, friends were primarily a source for shelter. Kelli (age 28) describes being at a friend's home and being offered the opportunity to shower. "*. . . as far as taking showers and things . . . sometimes some friends' moms would even offer it.*"

Strategies for bathing included using a friend's shower when "*sleeping over"* or "*couch surfing."* Others described meeting their hygienic needs by using bathrooms at fast food restaurants, gas stations, or wherever a public bathroom could be used that the individual could lock for privacy. A practice several participants called "*taking a bird bath."* One participant described how during the summer a swim in the ocean or fresh water lake provided a sense of feeling clean.

> *"Because it was um, summer time and warmer, I often just went swimming you know. Like in the ocean or… and I felt not clean but you know like salt is kind of a purifier…So I'd kind of wash up and jump in the – you know there's a fresh water place around that area too that I would go you know."* (Lita, age 26)

Another participant described how standing out in the rain provided a means to "shower" as well as launder the clothing she was wearing at the time.

> *"I never did laundry . . . if something that I was wearing began to stink I would quite literally take it off and just put something else on and that would be the end of that shirt. A lot of time when it would rain I would stand out in the rain. If it was summer time . . . If I stained a shirt I'd just take it off and put something else on. I was lucky enough to have friends. I'd be like can I wear that?"* (Sydney, age 26)

The above examples illustrate how the women used public spaces to meet private hygienic needs. Managing menses could be a challenge for these women if they were not able to find feminine hygiene products. Several participants described using towels or toilet paper to serve as sanitary napkins.

> *"There was a lot of finding towels and things like that. Wrapping them up, it wasn't pretty, yeah. I wish that would have been available. I would take toilet paper because that was useful. Anything I could find that would help, churches, hospitals, people weren't going to take it*

> *unless, and I mean they need that stuff. If that can be provided that's a really good thing, you know."* (Sydney, age 26)

Several of the women discussed carrying a small bag with toiletries so that when the opportunity arose they could take advantage of meeting their hygienic needs. Others would "*borrow from friends, "steal*" from stores or would scavenge for items such as toilet paper, soap, feminine and oral hygiene care products in friend's homes or in public restrooms. "*Tampons, definitely that was a commodity"* (Sydney, 26). *"Borrowing"* from friends was an important strategy for most of the women, however one of the women spoke about not taking anything from a friend's home since from her perspective this type of practice could jeopardize her ability to seek shelter from these friends.

Resourcefulness. All of the women who participated in the study described friends as a primary resource in their ability to survive. It was their friends who gave them a place to sleep, an opportunity to shower, food to eat, clothing and support. It was also "friends" that supported drug use or initiated an introduction to drug use. Regardless friends or peers were considered highly important to these women.

When faced with an illness, injury, or health issue, slightly more than half of the women surveyed (n = 5) described that they had gone or would go to a pharmacy and consult with the pharmacist in order to seek information about medication as well as information on managing simple illnesses or injuries. Other sources of information were sought through a kin connection or through friends. Most of the women didn't consider accessing the library for information regarding health. A few did see the library as a source for information, but not directly related to health. One woman reported that she would go into the library to get out of the cold, but not to seek

information. None of the women who participated in this study considered that the library had free access to computers.

> *Joy (age 31) "you wouldn't catch me at the library back in the day . . . I don't think I would have ever stepped foot in one. I would have never thought of it and if I did think of it I probably would have said oh they're going to tell me to leave . . ."*

Getting information to remain healthy was not a priority. As one participant, Kelli (28) noted, "*that was, like, the last concern."*

For some of the women (n = 3) although they did not maintain a routine connection with family, during times of crisis or in need of advice the women would reach out to kin.

> *"And people I would ask would just be people like friends or my mom or somebody, you know."* (Lita, age 26)

> *"I talked to my mom all the time. My mom's a nurse practitioner . . . she still loved me as her child."* (Jade, age 32)

> *"If I had a big issue I would probably tell my aunt what the issue was just to see if she was concerned."* (Sydney, age 26)

For other women (n = 5) advice or information was sought from on older friend, peers, or a friend's mother. "*My girlfriends basically or their mothers . . . she was like a second mother to me"* (Sarah, age 27). Several (n = 3) of the women described maintaining a close relationship with a friend whom they relied upon for advice, support, and shelter.

> *"I found someone that was older than me that also seemed to have an issue with drugs. Someone who seemed put together. Someone that didn't have any issue probably would not help somebody. I mean honestly that's just the way it is."* (Sydney, 26)

Joy (age 31) reports having a lot of people *"that cared about"* her, but were unhappy with the choices she had made. She spoke of having several friends who she

could ask for advice; however she preferred to seek advice and information from older adults such as her boss and his wife. Having worked for the restaurant for a long time, she describes her boss of *"kind of like my dad in a way."* She also describes seeking advice at times from people whom she had developed a relationship with whom she referred to as her "regulars" at the restaurant where she was employed.

Although school personnel were not individuals that these women sought for advice or support, the school environment was considered an important resource for a couple of these women. Sydney (age 26) describes her experience of being homeless during high school and credits the vocational school program as allowing her to be successful in completing high school and having a trade.

> *"I did trade school and the only reason why I did trade school was because it was right next to the high school. You'd go to high school half the day and believe it or not a lot of it that pushed me to go to school more is because I didn't have any place to go and when school is in session all of my friends are all in school. I had to go to school. I think the vocational schools kept me out of trouble and it made me, gave me a purpose."* (Sydney, 26)

For Kelli (age 28) going to school was hard and she had difficulty concentrating, however going to school was important since it provided her with something to do and for socialization.

One participant found comfort from the school nurse:

> *"I actually pretended that things were wrong with me a lot just so I could go sit there . . . and just because I could talk to her and stuff. I felt like there was of lot things I could say. Oh I have a blister or does that look okay? Just stuff like that. If she would see something wrong she would tell me. It was kind of like a checkup with a physician almost."* (Sydney, age 26)

The majority of participants (n = 7) dropped out of school or were experiencing homelessness once out of school. One woman left school due to her drug

use. Another woman left school because she was "too cool" for school. For one woman finishing school was impeded by her perceived barriers, primarily that of not having a permanent address and a lack of funds to pay for a parking pass so she could park her car at school:

> *"I was in my junior year . . . couldn't go back to school, um, because I didn't have like a permanent address anymore. And I was trying to go to school but I didn't have a parking pass . . . I got my GED."* (Lita, age 26)

Additional information associated with health that several of the women found lacking (n = 3) included "*the basics."* Joy (age 31) recounts how she did not have any skills or knowledge on *"how to do a checkbook. I didn't know how to go grocery shopping. I didn't know how to stock my medicine cabinet with appropriate things."* Lita (age 26) describes how due to her age and inexperience knowledge about coping or resources was lacking.

> *". . . possible resources we could have kind of shared with each other…when you're out there and you're all alone and you're young . . . I wasn't really taught all of this stuff that I needed to learn. Like I wasn't really taught coping skills . . ."*

Challenges encountered. The majority of the women discussed challenges that were closely related to mental health. Issues such as depression, suicide, anxiety and fear were expressed. A couple of the women (n = 2) had been raped and suffered from anxiety and posttraumatic stress. Some of the women (n = 4) spoke about feeling constantly worried or on edge due to the uncertainty of where they could go or what would happen to them.

> *"It was hard because I didn't really know where I was going to go . . . I felt very vulnerable*." (Lita, age 26)

> *"I think I've always had the depression, but I think the anxiety and the panic attacks . . . It's possible that it was going to happen anyway but*

> *it's also possible that from being worried and stressed and constantly on edge that could be the cost of it as well . . .*" (Lynn, age 28)
>
> *"Like nerve wracking like not knowing what's going to happen next . . . being scared that not having check-ups and making sure that you are ok physically."* (Sarah, age 27)

For others (n = 3) accessing dental and gynecological care were a challenge. The majority of the women (n = 8) reported that they did not access routine health care, nor did they think about their health especially because of the turmoil of experiencing homelessness. Only one participant reported that she did not think she had ever abandoned routine health care. Statements such as *"I did not care about health"* or *"I did not think about health"* were verbalized. Kay (age 23) replied with, *"I just really didn't have time to think about my health. It was really just like a chaotic time. You know."*

Several women (n = 2) reported that their substance abuse problem began during the period of time they were experiencing homelessness. Another couple of women (n = 2) described their substance abuse as resulting from prescribed medication for anxiety and pain. One woman's experience with substance abuse was not introduced until her 30's which is outside of the age parameter for this study, however the woman did describe using alcohol during the period of time she was experiencing homelessness. For the remaining women (n = 4) who participated in the study, substance use and alcohol use occurred prior to experiencing homelessness.

Joy (age 31) spoke about her long battle with addiction and homelessness. She spoke of how over time the greatest challenge she faced was not to commit suicide, *"towards the end not killing myself . . . I was just so sick and tired of being sick and*

tired." For Joy (age 31), an additional component to her challenge was in how she was treated when she did reach out for help.

> *"You say you want to kill yourself, you do know what happens? They put you on a wooden bed or whatever the crazy person bed is or where the people from jail go and they handcuff you and they have a fucking guard watch you and look at you and talk to the other guards 'oh, here's another crazy one.' And they treat you like shit . . . Don't tell anybody that. Are you crazy!"*
>
> *"Don't ever tell anybody you want to kill yourself. They're going to put you in a nut house. They're going to chain you to a bed. For being honest and saying you want to hurt yourself you get treated like a piece of shit, like you're doing something wrong when you're just trying to get help."* (Joy, age 31)

A lack of health insurance was also considered a challenge in managing health for those who were concerned about health. Not having health insurance or the financial capital to pay for health care was a barrier for the majority of the women. Although several of the women continued to have coverage through their parent, even when they were experiencing homelessness. Their routine health care was sporadic. One woman reported that she did not think she gave up on routine care. For another she reported that she kept up on her gynecological care. For Gabrielle (age 39), a lack of insurance or money to obtain her medication for her depression was reported as her greatest health challenge. Without health insurance she was unable to buy the medication and would go without which contributed to an increase in her mental health issues.

An individual's state of mind and how they she/he about themselves can be considered a barrier and challenge in maintaining health. For these women their sense of self and self-esteem was impacted by their experiences of homelessness. Although for some, events, which occurred prior to their experience of homelessness such as,

abuse, exposure to violence, and addiction continued to impact them. All but one of the women expressed a poor or negative sense of self during this period of homelessness. Kelli (age 28) stated she did not know how she felt about herself since she was *"just too busy . . . trying to stay alive"* (Kelli).

Descriptors the women used to describe how they felt about themselves included being embarrassed, and feeling *"less than."*

> *"Um, I was embarrassed. Um, embarrassed, alone. Um, helpless, hopeless. Ashamed, um, I felt dirty; like if people knew, if too many people knew not just my closest friends, you know, that I would be looked down upon. It's a really like low feeling . . . Yeah, I felt I don't know even the word for it. Less than."* (Lynn, age 28)

One woman who had been *"put out"* described how it felt to be out alone and recognizing that the only place she fit in was not the best for her.

> *". . . and you feel like the only people that you fit in are people like that too and they're usually all using drugs and drinking or whatever . . . I really felt like shit honestly. I um, I didn't have very high self-esteem. Um and I tried to pretend like I was very confident and like I was you know the cat's meow or whatever. I just really wanted, because I wanted to be but I really inside I was just dying, you know. Because I didn't have peace, like I wasn't at peace within myself. Like I didn't like who I was . . . You know what if these people can just do this to me than I really must be worthless . . ."*(Lita, age 26)

For others it was a struggle.

> *"I was underweight. I couldn't wear makeup or anything like that so I didn't feel good about myself like whether or not I looked good or died because it was just a struggle every day . . ."* (Sydney, age 26)

> *"I mean I always felt hopeless, didn't want to live anymore but I didn't actually sit there and think of ways to kill myself but I didn't think like 'I don't want to live. I hate my life. I hate myself.' But I never actually . . ."* (Kay, age 23)

> *"I didn't feel good about myself. I was insecure . . . I didn't feel I was worth anything . . . I just want to party and feel good in the moment and numb all the bad feelings."* (Joy, age 31)

> *". . . hated myself . . . I was an angry scared little girl . . . But I didn't act like I was . . . I acted the opposite to think—make people be scared of me . . . But really it was me that was the scared person."* (Jade, age 32)

Insights and suggestions. The insightfulness of these women and their responses to this question was illuminating. All the women reported that during the period of time they experienced homelessness they were unaware of resources that may have been available to them including where to obtain food stamps, and locate food banks, kitchens, or shelters. Those (n = 5) who had remained in school recalled some class or receiving information about health topics such as substance abuse, HIV, AIDS, and sex. However only one of the women recalled hearing information related to alternative topics such as *"stuff about nature. Berries you can't eat, what things you can't eat, poison ivy, poison oak . . ."* (Sydney, age 26).

Joy recalled having a DARE program at her school during the time she was enrolled. Although she considered the message to be important, program delivery was not appealing to these high school students and was considered "dork like."

> *I know they have the DARE program, but you got to make it cool. You have to make it like you want to be in it, like it's the cool thing to do, not like it's the dork like band geek thing to do. You have to make it like this is where you want to be, Like these are where the cool kids are, you know what I mean? You have to make it fun . . ."* (Joy, age 31)

The women expressed concern that there was not enough information about what is available is out there on the streets. All participants discussed the need for information on how to stay healthy and, resources they could access. Many of the women suggested that information was not clearly available so providing information was the most frequently reported suggestion.

When asked about availability of resources or personal knowledge of resources all of the women reported that they were not aware of what types of resources or information was available to them. For a few women (n = 2) how to find information was considered a barrier. Additionally, a few of the women reported that not only were they not aware of resources or information, but no one reached out to them.

> *". . . I know that they had those kinds of programs but I never knew about them. No one ever reached out to me about them. I didn't know how to, even if I wanted to do it I wouldn't know how."* (Kay, age 23)

Several of the participants (n = 2) had suggestions, which directly related to the perception or characteristics of the providers. Sarah (age 27) suggested that providers be *"open minded . . . try to be understanding."* Joy (age 31) suggested that health care providers *"not judge people"* and become educated on substance abuse or homelessness; *"not everyone that is homeless is a substance abuser."* She goes on to suggest that providers need to demonstrate compassion.

> *"Just try to, like, be compassionate, you know. There are so many people in the field that I don't know why they do it. If you're going to judge people and give them attitudes . . . You know so it just sucks to be judged."* (Joy, age 31)

Another participant (Lita, age 26) suggested health care providers reflect on their views or perception of homelessness. Using the term stigma Lita suggests that homelessness could happen to anyone. In her opinion information on the basic needs was important, but also on the needs for women who have sustained violence especially that of rape.

> *". . . rather than like stigmatizing it, really like try to be more like solution based and maybe like give people information . . . of places they can go like shelter or . . . I think that women who are homeless are preyed on . . . A lot of women are scared and they don't know what to do . . . More awareness of how to take care of their bodies after that . . . It's accessing it right."* (Lita, age 26)

Jade (age 32) suggested that health providers provide a list of different help resources, such as a packet of *". . . resources and stuff to help them."* Educational classes, especially free classes about that *"stuff,"* should be provided during the day so that individuals who are in need can attend. Classes that relate to topics of importance to this population would also provide a vehicle in which to distribute information or packets of resources to those who wanted the information.

For a few women (n = 3) information about nutrition, selection of foods that are the best for someone who is experiencing homelessness as well as where to find resources was considered critical information that health providers relay. Another suggested that providers ask if the individual had a safe place to go.

> *". . . I don't think I ever got asked up until just recently. Like now I think one of the main questions they have is do you have somewhere safe to go."* (Kelli, age 28)

The idea of providing appropriate resource information was somewhat universal among the women; however, suggestions on how to disseminate the information varied. For the majority of the women (n = 8), remaining anonymous was more important than the information.

> *"Offer as much information, just leave it out . . . Don't even approach the kids about it. Just leave it out where it can be seen . . . Just basic tips about being healthy . . . You can just take it. So leaving information out in the open like that kind of thing that would be very useful . . . It would have to be teenage friendly."* (Sydney, age 26)

Suggestions on how to accomplish this were asked of the participants and the women had some direction for health care providers. Some respondents (n = 2) suggested a phone line that could be accessed; another person thought that a phone line might not be accessible to all since many of the individuals experiencing homelessness had limited or no access to a phone.

Several of the women (n = 2) suggested when trying to reach the adolescent population especially those experiencing homelessness, information needed to be accessible, but it had to be left out or accessed through a center or van that did not require the individual to give an identifying information. "*It needs to be anonymous.*" Anonymity was important when seeking resources, as many of the women recall not wanting to be exposed and returned to a difficult situation or into state care.

Kelli (age 28) explained how she would not ever disclose information about her situation; however, had she been asked she probably would have replied and told someone about what was happening to her. *". . . because there was a few like guidance counselors or teachers that I couldn't help but to talk."*

Kelli suggested a place such as Walmart or another type of market could be a place to distribute information:

> *"'Cause I pay attention to those things . . . 'Cause when you're not busy when you're homeless, so you know there's time to stop and look at those things. We sometimes stop purposely just to take up a few minutes.*
>
> *"I always looked at all the brochures wherever I went. I looked for any type of help that I needed."* (Gabrielle, age 39)

In addition to information, supplementary suggestions on how the information for this population should be delivered were expressed. For a few of the women (n = 2) the manner in which the provider delivered the information was significant. Sydney (age 26) had provided some advice about the type of behavior the on how the provider should act when providing information or suggestions.

> *". . . when talking to teenagers and kids it's really important to be non-threatening or to be very nonchalant or be very cool and trying not to act like a parent, just be very like easy going about stuff . . . Pretend like you're not really interested."* (Sidney, age 26)

As part of the discussion regarding suggestions for providers, the women were also asked what advice they would provide for an adolescent experiencing homelessness. Although each woman had had a different experience, the commonalities in their advice to other teens had many similarities especially in speaking up for themselves, seeking a mentor, and getting an education. Lynn (age 28) tells them to *"speak up and let it be known."* Kelli (age 28) suggests that the adolescent just "*ask for help*" and Sarah (age 27) says "*stay in school . . . find somebody to talk to . . . ask for help and resources . . ."* Lita (age 26) would share her experiences and provide encouragement to the adolescent:

> *"I might relate some of my experiences and you know really tell them that you know they need to believe in themselves and really just try to get motivated to you know find something to do with themselves that's really productive and like find a way to get yourself into college because education is so important."* (Lita, age 26)

Another participant would let them know that she understands what they are going through.

> *"I would definitely understand what they're going through and I'd definitely tell them it gets better. And I would tell them that I know adults are scary people but you kind of need to reach out and get some help because this is no way to really live."* (Sydney, age 26)

The idea of counseling or providing mentorship to these adolescents was something that each of the women felt that they could and would provide once they had regained their equilibrium.

> *"I would tell that, um, you know, I was in their shoes and I can understand and relate to exactly what they're going through and how they're feeling." (*Lynn, age 28)

> *"I've always wanted to like help people that are in the same situation as I am. I would tell them to work really hard to try to get, um, to get an education . . . there's all this stuff that could help you get through college . . . protect yourself . . . I would want them to know that you*

don't have to be scared and you don't have to live like this." (Jade, age 32)

Discussion of Themes

The two themes that emerged from the data were found throughout six of the interviews. As Morse (2008) states, the themes provide a "meaningful" essence that runs through the data . . . sometimes in the background and sometimes in the fore-ground" (p. 727).

Survival takes precedence. After listening to the audiotapes and reading through the transcripts several times, the participants all discussed survival as their priority. Everyday survival was foremost in the minds of all participants. *"I was trying to survive . . . that was my biggest focus"* (Lita, age 26). *"It was a chaotic time, you know . . . I just really didn't' have time to think about my health*" (Kay, age 23). Staying alive was the main focus, however as a result of their attempts to survive, the choices each woman made led to significant consequences such as addiction, trauma, violence, and mental health issues. Concern for health, health promotion and meeting health needs were not at the forefront for these women. Other than meeting one's basic needs of food, shelter, safety, and hygiene, health care was not a high concern.

However, for one woman, finding places to maintain hygiene in being able to *"clean up*" was voiced as a high priority. This woman considered herself a *"survivor"* and frankly stated *"whatever I need, I'll get . . . Like, I'm not one to suffer or go without anything"* (Jade, age 32).

If health services were needed some of the women (n = 4) reported use of the emergency department or "*would wait it out."* Use of the emergency department or

urgent care center was used only if absolutely necessary. Some reported that they would seek care from their gynecologist for care or not seek health care at all.

Several of the participants (n = 5) provided an example of what type of event would necessitate a trip to the emergency department. For most participants, the event was a significant trauma such as a fracture or involvement in a motor vehicle accident. Kelli (age 39) stated:

> *"I cut my foot open pretty bad and my friends literally had to drag me to the hospital a day later. Like, I needed about sixteen stitches. That's how bad it was . . . just wrapped it you know . . . I literally would have to be dying to go to the hospital . . . and I even wouldn't go back to get the stitches out. I made somebody else take the stitches out."*

Some of the other women also described similar thoughts.

> *". . . if you had something that wasn't like life threatening or your weren't you know bleeding or you know had a concussion or something we didn't you know we just dealt with it . . . .like even now is that bad enough to go to the doctor, like should I go to the ER, . . ."* (Lita, age 26)

> *". . . I broke my foot. I had a car ran over my foot. I never went and got treatment for that so my foot has never been the same . . . I ended up having to go to the emergency but I didn't go for like a week because I don't, I figured they were just going to cast it or . . . I didn't know if was broken . . . then a week later it got worse and worse . . . and I was like okay, but again it was the emergency room and I didn't pay that bill . . . I had to get a cast and they told me I would need to see a special foot doctor . . . and possibly have surgery and stuff but I never did that. So I just did the cast and I cut it off myself . . ."* (Joy, age 31)

Paying to see a health care provider was a barrier to most of the women. Although several of the women (n = 3) during the period of time they were homeless did have some type of health insurance or worked, accessing routine health care was not considered a priority. As Kellie (age 28) spoke of going for health care she stated that she "*. . . would have to be dying . . .*" and that health care was "*. . . like the last*

concern." From her perspective, shelter was her first concern and then food; everything else was secondary.

Some of the women had been pregnant prior to being homeless, and for some pregnancy was the point at which they returned to their family, ending their homelessness. It was interesting to note that when the women became pregnant they did seek routine pre-natal care and received health insurance for themselves and their child. Retrospectively, some of the women spoke of how they wished they had taken better care of themselves and their health especially now that they are mothers and wish to be healthy so that they can be present for their children.

> *". . . because I always needed somewhere to stay so I just didn't mess around with that. I made sure I never put my hands on anything that wasn't—cause I didn't wanna jeopardize."* (Kelli, age 28)

Remaining invisible. Throughout each interview the women talked about the need to maintain their anonymity. They lived with the fear of being discovered and have to return to their families or ending up in foster care. They went to great lengths to keep up their appearance.

> *"Like I was the cleanest homeless person you ever did meet . . . I still wanted to look good. That was very important that I looked clean and that nobody knew really what was going on outside of."* (Joy, age 31)

> *". . . but I mean like I would always make sure like I kept up my appearance and stuff like that . . . that was important to me. Things like those were . . . because most of the things I did I did with my looks and my body."* (Jade, age 32)

> *"I kept up outer appearing, but I was not trying to go to the dentist. Well, I mean, I brushed my teeth. That's why I brushed my teeth so much because I was just not wanting to go to the dentist."* (Sydney, age 26)

The school nurse was not a person to whom these women turned to for support or advice. For one individual the school nurse was not someone she felt she could

even approach. *"The nurse was always brash . . . very black and white, very short in their answers and such"* (Kelli, age 28). Several of the women (n = 4) relayed that they could not *"share the secret"* or *"I was kinda taught not to ask for help . . . cause . . . by asking for help you're letting in on secrets"* (Kelli). Fear of exposure or repercussion were cited as the primary reasons for not sharing or asking for help from teachers, school nurses, or guidance counselors. As several participants noted, the individuals to whom they would want to reach out would have to report back to the respective authorities.

> *"I'm sure the guidance counselors or even the principal. One of my teachers, I could have talked to any of them but then again it falls back to you would have to report it and then it's just really scary. If there was a place for kids to go. It's sad because there's always going to be a repercussion . . . It's a tough situation, you know."* (Lynn, age 28)

Joy (age 31) expressed concern about the school nurse telling her mother about the advice she sought especially with sexual activity and drug use. "*I would have never said that to the school nurse. They would tell on me*." The remaining women either dropped out of school or had experienced homelessness after leaving school. Only one woman actually felt "comfort" with her school nurse. She sought her advice, but would not disclose to the nurse her state of homelessness for fear of being returned to foster care.

Summary

In summary, this study revealed that survival and maintaining their invisibility as homeless overshadowed the ability of these women to focus on their health as a priority during their periods of homelessness. It is also important to consider that in normal adolescence there is component of the personal fable: "everyone is looking at me or knows what I am thinking" (Garzon & Dunn, 2013). In spite of this reality,

these participants were incredibly resourceful and used a number of creative strategies to address their basic needs confronting them on a daily basis. As was expected, they encountered numerous challenges in meeting their health needs and gave insightful recommendations for nurses and other health care providers who can have an important impact on female adolescents who may be homeless in the future.

Chapter V

Conclusion and Implications

This study explored women's experiences related to their health during periods of homelessness when they were adolescents. The research questions for this study were:

- What approaches did women use to maintain their health while they experienced homelessness as adolescents?
- What resources did women use during the time they experienced homelessness in adolescence in order to meet their basic needs and to maintain their overall well-being?
- What challenges did the women encounter in meeting their health needs?
- What suggestions do these women have for nurses and other health care providers to assist in meeting the health needs of female adolescents who are homeless?

Main Findings

Chapter one provided an introduction of the persistent problem of homelessness in the adolescent population. The literature review in chapter two revealed a focus on chronic homelessness. In contrast the participants in this study experienced homelessness intermittently with a duration lasting one week to several months over a period of fourteen years.

Difficulty in obtaining accurate estimates of the prevalence of homelessness in this population and the lack of a consistent definition of adolescence and homelessness makes it difficult to generalize research findings. The literature that is related to

adolescence and homelessness includes both genders. What was striking in the literature review was the extremely limited information specific to adolescent females who are homeless. Given the unique needs of the female population, a call for research to increase our understanding of the experiences of adolescents obtained from an emic perspective was underscored.

The participants in this study shared some commonalities. All had experienced some period of homelessness and all were mothers at the time of the interview. Additionally all of the women could be considered as having had family dysfunction either due to substance abuse or other type of abuse. The majority of the women (n = 8) also had completed their education, had some college courses or had a GED and was in recovery for substance abuse.

The circumstances leading to the participants' homelessness were varied and consistent with the literature (Hyde, 2005; Mallett et al., 2005; Reid et al., 2005; Tyler, 2006; van den Bree et al., 2009). For six women, the decision to leave home was due to family discord, physical abuse, and/or substance abuse; two were *kicked out* from their home; one was removed from her family and placed in foser care and ran away from foster care. Once away from home all of these women described desperation in trying to maintain their existence. They used a number of approaches and resources to attempt to meet their basic needs. Similar to the findings from Bender et al. (2007), the importance of non-homeless friends was critical to this population in accessing resources to provide for shelter and hygiene. Four participants described using strategies such as stealing to obtain food and meet hygienic needs and falsifying

documents to obtain shelter. Kidd and Davidson (2007) reported similar findings in their qualitative study on homeless youth in Toronto and New York.

Several studies examining homeless youth regarding their experiences of illness and health care reported that during times of illness, females were more likely to ask a friend to accompany them to provide support and protection (Ensign & Bell, 2004; Ensign & Panke, 2002). Females during times of illness reported increased feelings of vulnerability and concerns for their safety. One of the few studies that explored the lives of homeless young women living on the streets in Canada did not report the idea of reliance on friends as a source of support. In all of these studies "friends' is not defined. Participants from one study reported that friendship was not a term they used lightly and trust of another person was not easily given (Bender et al., 2007).

Sex as a survival strategy, described in the literature by a number of authors (Bender et al., 2007; Edidin et al., 2012; Ensign, 2001; Greene, et al., 1997; Rew & Horner, 2003; Rice et al., 2013; Tyler & Johnson, 2006; Whitbeck et al., 2004) was suggested by four participants. However none of the participants overtly described prostitution but rather *using men*, or *conveniently falling in love* as strategies to meet their needs for shelter. Although these behaviors are not consistent with pro-social norms, they do reflect resourcefulness and attempts to survive.

Unlike what has been mentioned in a few studies (Bender et al., 2007; Oliver, 2013; Rew & Horner, 2003; Rice, Monro, Barman-Adhikari, & Young, 2010) these participants did not use the library to access information either through the computer or in print. In fact a few stated that they would not think about the library as a

resource; nor did they realize libraries had available computers for use. One participant believed she would be *"asked to leave if she entered into a library"* and another felt that the *"library was only a place for nerds."*

Unlike some of the literature that addresses panhandling, use of shelters (Ensign & Gittelshohn, 1998) and food kitchens by adolescents who are homeless these participants did not engage in these activities. When asked about resources such as shelters and food kitchens, the participants reported not having knowledge of such resources. According to Bender et al. (2007) youth reported that shelters were safe and adequate. Being on the streets and forming peer connections with other homeless youths also allowed them to learn about these available resources. Although several of the participants did speak of being with a group of other homeless youth and relying on them for information, they were seeking guidance to meet day to day needs from other women they considered to be experienced and knowledgeable.

Consequences of homelessness described by these women were also consistent with the findings of numerous authors. Issues such as rape, sexually transmitted diseases and substance abuse were noted (Edidin et al., 2012; Hodgson et al., 2013; Robertson & Toro, 1999). The majority of the participants discussed mental health issues or exacerbation of previous mental health disorders such as anxiety, depression, and post-traumatic stress; this finding is also consistent with the literature (Edidin et al.; Gwadz et al., 2007). Although eight of the women did not have a diagnosis of depression prior to experiencing homelessness, two thought the symptoms had been present for years but never confirmed. Events occurring during the experience of

homelessness and for a couple of the women prior to experiencing homelessness were thought to have contributed to their post-traumatic stress disorders.

Edidin et al. (2012) suggests there are higher levels of post-traumatic stress disorders in the homeless population of both genders. Gwadz et al. (2007) reported that PTSD was more common for females and that depression and anxiety was a comorbidity associated with PTSD. Consequences of experiencing homelessness impacted the participants in multiple ways. For some the trauma of certain events experienced during that period of time such as rape, beatings, and exposure to violence, and dependence on others for survival had a serious effect on their mental health. Five participants used a number of approaches to conceal they were homeless. Appearance was an important concern to the women, which enabled them to *"maintain their secret."* Although there are references to this population as being "hidden" in the literature, not many studies explicitly reported attempts by homeless individuals to keep their homelessness hidden.

One striking finding in this study was the emphasis on their oral hygiene by all participants. They went to great efforts to keeping their teeth clean. The literature suggests that many youth suffer from poor oral hygiene and consequently are at greater risk for caries and gum disease, however limited data is available on this finding (Boivin et al., 2005; Feldman & Middleman, 2003). In fact little research has addressed oral health in adolescent/youth that are homeless. Previous research has explored accessing health care as well as perceived quality of health care received by this population (Dawson & Jackson, 2013; Ensign, 2001; Ensign & Bell, 2004; Ensign & Gittelshohn, 1998; Ensign & Panke, 2002; Ensign & Santelli, 1997; Haldenby et al.,

2007; Hudson et al., 2010; Reid et al., 2005; Rew, 2003). Eight participants described their constant efforts on meeting day-to-day survival needs overshadowed their health needs. The women only used the emergency department [ED] or urgent care centers as a last resort, often not returning for follow up visits, which is consistent with the literature. One participant described her extremely negative experience with health care providers when she went to an ED after an attempted suicide. Another participant voiced her own dislike of healthcare providers. Although the ED is noted to be a source of primary health care for this population, several authors in Seattle (Barry et al., 2002; Ensign & Panke, 2002) and Canada (Reid et al., 2005) noted that youth-centric health care practices are needed to engage youth to return in the future for health issues. Several studies suggest that reasons for avoiding health care centers were related to the participant's perception of stigmatization and hostility from health care providers (Ensign & Panke; Hudson et al.; Klein et al., 2000; Reid et al.).

The challenges these participants countered in meeting their health needs was consistent with the literature. The women described a lack of financial capital to pay for health care or for medication. Several women reported that it would be pointless to seek health care since they could not afford to pay for medication. Additional reasons cited in the literature relate to the perception that there is no need to access healthcare, as they do not have any health problems (Dawson & Jackson, 2013; Edidin et al., 2012). None of the women who participated in the study suggested that they considered themselves unhealthy during that period of time.

As stated earlier, these participants were not aware of available resources or how to find out about them. There were many available resources in this community at

the time when these women were homeless including food pantries in churches, shelters, and free health clinics. It is concerning that these participants were not successful in finding what they needed to improve their situation. Albeit some of the "hot" lines are new and may not have existed during the period of time they were homeless. Some authors have discussed the presence of a community of homeless peers who are sources of information needed for survival on the streets (Bender et al., 2007). Other studies suggest that perception of support and available materials is limited and not always easily accessible (Haldenby et al., 2007; Pergamit & Ernst, 2010). When the participants needed advice regarding health issues, they reached out to a family member, an adult parent figure, or an older woman on the street for support and guidance. This finding is also consistent with the work of Ensign and Gittelsohn (1998) and Ensign and Panke (2002).

One of the greatest contributions of this study is the insightful recommendations these participants provided for nurses and other health care providers. The women were very articulate and willing to participate in this discussion with the hope of helping other adolescents in the future. They identified the need for information about the location of food pantries and youth centric shelters as well as where this information should be placed. Bus stations, pharmacies, Walmart or other low budget shopping stores in the community and even schools were identified as key locations. A well-advertised hotline that provided information but did not require the adolescents' name was noted to be very important. One participant recommended the availability of short classes addressing life skills, nutrition and basic health needs offered in an outreach center.

The need to remain anonymous even when obtaining information, health care and resources was underscored by several participants. The fear of being identified as an adolescent who is unsheltered was the primary barrier to accessing any assistance. Several participants stressed the need for health providers to assume a nonchalant approach whereby adolescents would not feel pressured to divulge their situation. Last, health care providers need to reach out to this population with a sincere and nonjudgmental attitude when the do encounter individuals who are homeless. Providers should include a homeless assessment along with their abuse assessment with each encounter. One participant believed they would be more comfortable accessing health care if a van was available.

Limitations

There are a number of limitations in this study. The sample size was small, lacked ethnic diversity and was confined to one geographical area. All of the participants had time constraints when planning for the interview. Four participants had one child with them during their interview and three had to leave to pick up their children, which was distracting at times.

Implications

Knowledge development. The findings of this study raise number of potential areas for future research. As a next step, this researcher plans on compiling a list of resources including shelters, food pantries, and free health clinics that will be given to adolescents who present as homeless in this community. They will then be asked to give feedback regarding their knowledge of these resources and where they obtained

this information. Research related to the use of technology with this generation of adolescence is another area warranting future research.

Nursing education and practice. Nurses and nurse practitioners are in a pivotal position to reach out to this population in emergency departments and primary care settings. Based on recommendations from the American Academy of Pediatrics (2008), providers need to include an assessment for the risk of homelessness with each client encounter. Information about resources for adolescents who are homeless can also be placed in practice settings. A health facility for this population needs to be youth centric. The 45th Street Clinic (Barry et al., 2002), a walk-in free clinic for adolescents, in Seattle can serve as a model. This clinic is open two days a week in the evening and provides care for adolescents, ages 12 to 23. The adolescent's strengths and skills are explored and their need for independence is acknowledged. Since these youth are considered emancipated, they are not required to present identification and can use their street names. Paper work has been adapted to be user friendly by this population. Hygiene packets could be placed in a central location so that with each encounter the clients could serve themselves without having to ask for items.

School nurses are another important resource that can be tapped. As the study implies, keeping the issue hidden or secret is a strategy used by the adolescent female to avoid exposure. However several did state that if someone reached out to them, they might have broken their silence.

Collaboration with pharmacists in the community to strategically place information related to health, use of alternative therapies, and indications for over the counter medication will also be important. Considering the importance of dental care,

providing small bags, which contain essential necessary items such as a toothbrush, toothpaste, and mouthwash, should be considered. Additional resources such as tampons strategically placed in bathrooms at schools, hospital EDs, and in primary care centers will address some of the needs identified by these participants.

Appendix A

Institutional Review Board Approval

THE
UNIVERSITY
OF RHODE ISLAND
DIVISION OF RESEARCH
AND ECONOMIC
DEVELOPMENT

OFFICE OF RESEARCH COMPLIANCE
70 Lower College Road, Suite 2, Kingston, RI 02881 USA
p: 401.874.4328 f: 401.874.4814 uri.edu/research/tro/compliance

THINK BIG WE DO℠

DATE:	April 10, 2013
TO:	Ginette Ferszt
FROM:	University of Rhode Island IRB
STUDY TITLE:	[425295-2] Exploring the Health of Women Who Experienced Homelessness During Adolescence
IRB REFERENCE #:	HU1213-121
SUBMISSION TYPE:	New Project
ACTION:	APPROVED
APPROVAL DATE:	April 9, 2013
EXPIRATION DATE:	March 20, 2014
REVIEW TYPE:	Full Committee Review

Thank you for your submission of New Project materials for this research study. University of Rhode Island IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Full Committee Review based on the applicable federal regulation.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office.

Please note that all research records must be retained for a minimum of three years.

Based on the risks, this project requires Continuing Review by this office by March 20, 2014. Please use the appropriate renewal forms for this procedure.

If you have any questions, please contact us by email at compliance@ds.uri.edu. Please include your study title and reference number in all correspondence with this office.

Please remember that informed consent is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the study via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document unless the signature requirement has been waived by the IRB.

Appendix B

Informed Consent

The University of Rhode Island
College of Nursing
White Hall 313
Kingston, RI

Exploring the Health of Women

Who Experienced Homelessness During Adolescence

CONSENT FORM FOR RESEARCH

You have been invited to take part in a research project described below. The researcher will explain the project to you in detail. You should feel free to ask questions. If you have more questions later, Ginette Ferszt PhD, (401- 874-5345) or Claire Creamer PhD(c), RN, (401-456-9597) the person(s) mainly responsible for this study will discuss them with you. You must be at least 18 to 45 years old to be in this research project.

Description of the project:

My name is Claire Creamer and I am a working on a research study in nursing at the University of Rhode Island. For my research I am interested in learning about how you took care of your health while you did not have a place to sleep at night. With this information I hope to be able to help nurses and other professionals to improve the health of others.

What will be done:

If you decide to take part in this study here is what will happen. If you agree to take part you will sign a consent form and then participate in an audiotaped interview, which will last about 1 ½ to 2 hours. The interview will take place at a location that is agreed upon by the interviewer and yourself. The interviews will focus on how you took care of your health, how you got health information, and what suggestions you have for nurses and other professionals.

Risks or discomfort:

There are some risks involved in participating in this study. You may experience some emotional discomfort when discussing your experiences of homelessness. If this occurs we will stop the interview immediately and if you want to see a counselor, a referral will be made to a counselor in your agency.

Benefits of this study:

There are no direct benefits to you personally for participating in this study, however your stories and experiences will help nurses and other professionals to improve health of others.

Confidentiality:

The only people who will have access to the information you provide, including your audiotapes, will be the researchers. For the study you will be asked to choose a name of your choice that will be used during the audiotaped interview. All of the records will be kept in a locked box in a locked office located in room 313, White Hall, University of Rhode Island.

There are some limits to confidentiality. This study is confidential. The researcher will emphasize that study is confidential. However if you state that you will harm yourself or another person, or that a child, an elderly or disabled individual is being abused or neglected that information will be reported to the appropriate agency.

We have applied for a **Certificate of Confidentiality** which will protect the investigators from being forced to disclose identifying information on research participants in any civil, criminal, administrative, legislative, or other proceeding, whether at the federal, state, or local level.

Decision to quit at any time:

The decision to take part in this study is up to you. You do not have to participate. Whether you choose to participate or not will have no influence on the current services you are receiving. If you decide to take part in the study, you may quit at any time.

Rights and Complaints:

If you are not satisfied with the way this study is performed, you may discuss your complaints with Ginette Ferszt PhD (401-874-5345) anonymously, if you choose. In addition, if you have questions about your rights as a research participant, you may contact the office of the Vice President for Research, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

You have read the Consent Form. Your questions have been answered. Your signature on this form means that you understand the information and you agree to participate in this study. **You agree to have your interview audiotaped.**

Signature of Participant	Signature of Researcher
Typed/printed Name	Typed/printed name
Date	Date

AUDIO INFORMED CONSENT:
The University of Rhode Island
College of Nursing
White Hall 313
Kingston, RI

Exploring the Health of Women

Who Experienced Homelessness During Adolescence

CONSENT FORM FOR RESEARCH

I agree to having my interview audiotape recorded by Claire Creamer who will be conducting the interview. I can change my mind regarding audiotaping at any time. I understand that only Ms. Creamer, Ginette Ferszt and Diane Martins (nurse researchers) and a medical transcriber will have access to my audiotapes. I will be using a fictitious or made up name during the interview.

Participant	Researcher
_____	_____
Name Printed	Name Printed
_____	_____
Signature	Signature
_____	_____
Date	Date

Appendix C

Exploring the Health of Women

Who Experienced Homelessness During Adolescence.

Code number_____

Demographics

Age _____ Ethnicity _____ Race _____ Religion _____

Education: Current level:

How many schools did you attend?
Elementary
Middle
High School
Any College

Period of time without shelter: _____

Age(s) during that time: _____

Kinds of places you stayed during this
Time: _____

Insurance: yes _____ no _____

Where do you get your health care now? _____

Do you have any medical problems? _____

Current Medications (prescription or non): _____

Mental health history: _____

Appendix D

Proposed Interview Questions

My name is Claire Creamer and I am interested in learning about how you took care of your health during a time when you were without shelter. As the expert, what you experienced will help nurses and other professional to better serve other people in the future.

For each of the following questions I will ask you, I want you to think back to when you were a teenager and you did not have a regular place to stay.

In that time period what kinds of things did you do to take care of your health?

When you look back what do you think was your biggest health issue?

During that time, were you able to stay safe?

What was your biggest challenge?

When you were hurt or feeling ill what did you do?

Were there any free clinics available to you? If so, did you use the clinic?

During that time was there a particular person(s) who you could go to for help, advice and/or support?

Were you able to find or get information to help you stay healthy?

Is there anything about keeping healthy that you wish someone had told you?

How did you feel about your-self as a person during that time?

If there was one thing that you would want nurses and other health care providers to know what would that be.

Table 1

Demographics

Participant	**1 (Joy)**	**2 (Kay)**	**3 (Jade)**	**4 (Lita)**	**5 (Lynn)**	**6 (Sarah)**	**7 (Sydney)**	**8 (Kelli)**	**9 Gabrielle)**
Age	31	23	32	26	28	27	26	28	39
Race	White	White	White	White	White	White	White	White	White
Education	Some college	8th grade GED	College	GED	Middle school	GED plus	GED Trade	High school	Some college
Period of homeless	Age 15-26 Longest was several months at a time	2 weeks	In and out Kicked out at 16	On and off since 14, 2½ years longest	7 months longest period age 14-27	18 months was about 21 years old when homeless	Approx. 6 months at age 13 and again from 16-18	14 years on and off	One week
Type of places lived during homelessness	Couches shelters abandoned buildings	Car, home, sober house apt	Friends' houses, car, hotel	Friends Car Fishing boat	Cars and friends	Friends	Outside, friends,	Street, couch surfed, basement	Friend
Insurance during homelessness	None	Yes until age 18	Until age 18	None	None	None	Had coverage when in state custody otherwise none	None	Yes

Bibliography

Abramovich, I. A. (2012). No safe place to go - LGBTQ youth homelessness in Canada: Reviewing the literature. *Canadian Journal of Family and Youth, 4(*1), 29-51. Retrieved from http://ejournals.library.ualberta.ca/index.php/cjfy/article/view/16579

American Academy of Pediatrics. (2008). *Bright futures recommendations for periodic pediatric health care.* Retrieved from American Academy of Pediatrics website: http://brightfutures.aap.org/pdfs/AAP_Bright_Futures_Periodicity_Sched_101107.pdf

American Psychological Association. (2002). *Developing adolescents: A reference for professionals.* Accessed at http://www.apa.org/pi/families/resources/develop.pdf

Ammerman, S. D., Ensign, J., Kirzner, R., Meininger, E. T., Tornabene, M., Warf, . . . Post, P. A. (2004). *Homeless young adults ages 18-24: Examining service delivery adaptations.* Retrieved from National Health Care for the Homeless Council website: http://www.nhchc.org/wp-content/uploads/2011/10/younghomelessadult1.pdf

Annie E. Casey Foundation. (2013a). *2013 kids count data book: State trends in child well-being.* Retrieved from Kids Count Data Center website: http://datacenter.kidscount.org/files/2013kidscountdatabook.pdf

Annie E. Casey Foundation. (2013b). *2013 Rhode Island kids count factbook.* Retrieved from Rhode Island KIDS COUNT website:

http://www.rikidscount.org/matriarch/documents/2013%20Factbook-EntireBook-WithoutArtandPoemsNEW.pdf

Antoniades, M., & Tarasuk, V. (1998). A survey of food problems experienced by Toronto street youth. *Canadian Journal of Public Health, 89*(6), 371-375. Retrieved from http://journal.cpha.ca/index.php/cjph/article/view/1133/1133

Aratani, Y. (2009). *Homeless children and youth: Causes and consequences* [brief], 1-14. New York, NY: National Center for Children in Poverty. Retrieved from: http://hdl.handle.net/10022/AC:P:8879

Ashiabi, G. S., & O'Neal, K. K. (2008). A framework for understanding the association between food insecurity and children's developmental outcomes. *Child Development Perspectives*, *2*(2), 71-77. doi:10.1111/j.1750-8606.2008.00049.x

Baron, S. (2013). Why street youth become involved in crime. In S. Gaetz, B. O'Grady, K. Buccieri, J. Karabanow, & A. Marsolais (Eds.), *Youth homelessness in Canada: Implications for policy and practice* (pp. 353-368). Retrieved from Canadian Homelessness Research Network website: http://www.homelesshub.ca/ResourceFiles/Documents/21BARONweb.pdf

Barry, P. J., Ensign, J., & Lippek, S. H. (2002). Embracing street culture: Fitting health care into the lives of street youth. *Journal of Transcultural Nursing, 13*(2), 145-152. doi:10.1177/104365960201300208

Bearsley-Smith, C. A., Bond, L. M., Littlefield, L., & Thomas, L. R. (2008). The psychosocial profile of adolescent risk of homelessness. *European Child & Adolescent Psychiatry, 17*(4), 226-234. doi:10.1007/s00787-007-0657-5

Beech, B. M., Myers, L., Beech, D. J., & Kernick, N. S. (2003). Human immunodeficiency syndrome and hepatitis B and C infections among homeless adolescents. *Seminars in Pediatric Infectious Diseases, 14*(1), 12-19. doi:10.1053/spid.2003.127212

Beharry, M. S. (2012). Health issues in the homeless youth population. *Pediatric Annals, 41*(4), 154-156. doi:10.3928/00904481-20120307-12

Bender, K. A., Ferguson, K., Thompson, S., Komlo, C., & Pollio, D. (2010). Factors associated with trauma and posttraumatic stress disorder among homeless youth in three US cities: The importance of transience. *Journal of Traumatic Stress, 23*(1), 161-168. doi:10.1002/jts.2050

Bender, K. A., Thompson, S. J., Ferguson, K. M., Yoder, J. R., & Kern, L. (2013). Trauma among street-involved youth. *Journal of Emotional & Behavioral Disorders*. doi:10.1177/1063426613476093

Bender, K. A., Thompson, S. J., McManus, H. Lantry, J., & Flynn, P. M. (2007). Capacity for survival: Exploring strengths of homeless street youth. *Child Youth Care Forum, 36*(1), 25-42. doi:10.1007/s10566-006-9029-4

Benoit-Bryan, J. (2013). *A decade of trends in crisis connections handled by the National Runaway Safeline*. Retrieved from National Runaway Safeline website: http://www.1800runaway.org/assets/1/7/Trend_report_2013_Final.pdf

Boivin, J. F., Roy, É., Haley, N., & Galbaud du Fort, G. (2005). The health of street youth: A Canadian perspective. *Canadian Journal of Public Health, 96*(6), 432-437. Retrieved from http://journal.cpha.ca/index.php/cjph/article/view/644/644

Bourgois, P., Prince, B., & Moss, A. (2004). The everyday violence of hepatitis C among young women who inject drugs in San Francisco. *Human Organization, 63*(3), 253-264. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1458969/

Bousman, C. A., Blumberg, E. J., Shillington, A. M., Hovell, M. F., Ji, M., Lehman, S., & Clapp, J. (2005). Predictors of substance use among homeless youth in San Diego. *Addictive Behaviors, 30*(6), 1100-1110. doi:10.1016/j.addbeh.2004.10.006

Breuner, C, C., Barry, P. J., & Kemper, K. J. (1998). Alternative medicine use by homeless youth. *Archives of Pediatric & Adolescent Medicine, 152*(11), 1071-1075. doi:10.1001/archpedi.152.11.1071

Burt, M. (2002). Reasons to invest in adolescents. *Journal of Adolescent Health, 31*(Suppl. 6), 136-152. doi:10.1016/S1054-139X(02)00486-X

Chamberlain, C., & Johnson, G. (2011). Pathways into adult homelessness. *Australian Journal of Sociology, 49*(1), 60-77. doi:10.1177/1440783311422458

Chamberlain, L. B. (2009). *The amazing adolescent brain: What every educator, youth serving professional and healthcare provider needs to know*. Retrieved from Institute for Safe Families website: http://www.instituteforsafefamilies.org/materials/m/amazing-teen-brain-what-parents-need-know

Chen, X., Tyler, K. A., Whitbeck, L. B., & Hoyt, D. R. (2004). Early sexual abuse, street adversity, and drug use among female homeless and runaway adolescents in the Midwest. *Journal of Drug Issues, 34*(1), 1-22. doi:10.1177/002204260403400101

Christiani, A., Hudson, A. L., Nyamathi, A., Mutere, M., & Sweat, J. (2008). Attitudes of homeless and drug-using youth regarding barriers and facilitators in delivery of quality and culturally sensitive health care. *Journal of Child & Adolescent Psychiatric Nursing, 21*(3), 154-163. doi:10.1111/j.1744-6171.2008.00139.x

Cleverley, K., & Kidd, S. A. (2011). Resilience and suicidality among homeless youth. *Journal of Adolescence, 34*(5), 1049-1054. doi:10.1016/j.adolescence.2010.11.003

Coates, J., & McKenzie-Mohr, S. (2010). Out of the frying pan, into the fire: Trauma in the lives of homeless youth prior to and during homelessness. *Journal of Sociology & Social Welfare, 37*(4), 65-96. Retrieved from http://www.wmich.edu/hhs/newsletters_journals/jssw_institutional/institutional_subscribers/37.4.Coates.pdf

Cochran, B. N., Stewart, A. J., Ginzler, A. J., & Cauce, A. M. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health, 92*(5), 773-777. doi:10.2105/AJPH.92.5.773

Coles, E., Themessl-Huber, M., & Freeman, R. (2012). Investigating community-based health and health promotion for homeless people: A mixed methods review. *Health Education Research, 27*(4), 624-644. doi:10.1093/her/cys065

Collins, P., & Barker, C. (2009). Psychological help-seeking in homeless adolescents. *International Journal of Social Psychiatry, 55*(4), 372-384. doi:10.1177/0020764008094430

Corbin, J., & Morse, J. M. (2003). The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive topics. *Qualitative Inquiry, 9*(3), 335-354. doi:10.1177/1077800403009003001

Corliss, H. L., Goodenow, C. S., Nichols, L., & Austin, S. B. (2011). High burden of homelessness among sexual-minority adolescents: Findings from a representative Massachusetts high school sample. *American Journal of Public Health, 101*(9), 1683-1689. doi:10.2105/AJPH.2011.300155

Council on Community Pediatrics. (2013). Providing care for children and adolescents facing homelessness and housing insecurity. *Pediatrics, 131*(6), 1206-1210. doi:10.1542/peds.2013-0645

culture. (n.d.). In *The American Heritage® New Dictionary of Cultural Literacy, Third Edition*. Retrieved September 28, 2013, from Dictionary.com website: http://dictionary.reference.com/browse/culture

Dachner, N., & Tarasuk, V. (2002). Homeless "squeegee kids": Food insecurity and daily survival. *Social Science & Medicine, 54*(7), 1039-1049. doi:10.1016/S0277-9536(01)00079-X

Dachner, N., & Tarasuk, V. (2013). Homeless youth, nutritional vulnerability, and community food assistance programs. In S. Gaetz, B. O'Grady, K. Buccieri, J. Karabanow, & A. Marsolais (Eds.), *Youth homelessness in Canada: Implications for policy and practice* (pp. 131-145). Retrieved from Canadian Homelessness Research Network website: http://www.homelesshub.ca/Library/8-Homeless-Youth-Nutritional-Vulnerability-and-Community-Food-Assistance-Programs-55626.aspx

Darkwah, V., Yamane, H., Richter, S., Caine, V., Maina, G., Chambers, T., & Johnson, L. (2012). A systematic review on the intersection of homelessness and healthcare in Canada. *Journal of Nursing Care, 1*(5). doi:10.4172/2167-1168.1000115

Dawson, A., & Jackson, D. (2013). The primary health care service experiences and needs of homeless youth: A narrative synthesis of current evidence. *Contemporary Nurse, 44*(1), 62-75. doi:10.5172/conu.2013.44.1.62

Denzin, N. K., & Lincoln, Y. S. (2011). The discipline and practice of qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed., pp. 1-20). Los Angeles, CA: Sage.

Doroshenko, A., Hatchette, J., Halperin, S. A., MacDonald, N. E., & Graham, J. E. (2012). Challenges to immunization: The experiences of homeless youth. *BMC Public Health*, *12*(338). doi:10.1186/1471-2458-12-338

Dorsen, C. (2010). Vulnerability in homeless adolescents: A concept analysis. *Journal of Advanced Nursing, 66*(12), 2819-27. doi:10.1111/j.1365-2648.2010.05375.x

Draucker, C. B., Martsolf, D. S., & Poole, C. (2009). Developing distress protocols for research on sensitive topics. *Archives of Psychiatric Nursing, 23*(5), 343-350. doi:10.1016/j.bbr.2011.03.031

Dworsky, A., & Courtney, M. E. (2009). Homelessness and the transition from foster care to adulthood. *Child Welfare, 88*(4), 28-56.

Edidin, J. P., Ganim, Z., Hunter, S. J., & Karnik, N. S. (2012). The mental and physical health of homeless youth: A literature review. *Child Psychiatry Human Development, 43*(3), 354-375. doi:10.1007/s10578-011-0270-1

Ensign, J. (2000). Reproductive health of homeless adolescent women in Seattle, Washington USA [Abstract]. *Women & Health, 31*(2-3), 133-151.

Ensign, J. (2001). "Shut up and listen": Feminist health care with out-of-the-mainstream adolescent females. *Issues in Comprehensive Pediatric Nursing, 24*(2), 71-84. doi:10.1080/01460860119440

Ensign, J., & Bell, M. (2004). Illness experiences of homeless youth. *Qualitative Health Research. 14*(9), 1239-1254. doi:10.1177/1049732304268795

Ensign, J., & Gittelsohn, J. (1998). Health and access to care: Perspectives of homeless youth in Baltimore City, USA. *Social Science & Medicine, 47*(12), 2087-2099. doi:10.1016/S0277-9536(98)00273-1

Ensign, J., & Panke, A. (2002). Barriers and bridges to care: Voices of homeless female adolescent youth in Seattle, Washington, USA. *Journal of Advanced Nursing, 37*(2), 166-172. doi:10.1046/j.1365-2648.2002.02067.x

Ensign, J., & Santelli, J. (1998). Health status and service use. Comparison of adolescents at a school-based health clinic with homeless adolescents. *Archives of Pediatrics & Adolescent Medicine, 152*(1), 20-24. doi:10.1001/archpedi.152.1.20

Farrow, J. A., Deisher, R. W., Brown, R., Kulig, J. W., & Kipke, M. D. (1992). Health and health needs of homeless and runaway youth: A position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health, 13*(8), 717-726. doi:10.1016/1054-139X(92)90070-R

Feldmann, J., & Middleman, A. B. (2003). Homeless adolescents: Common clinical concerns. *Seminars in Pediatric Infectious Diseases, 14*(1), 6-11. doi:10.1053/spid.2003.127211

Feng, C., DeBeck, K., Kerr, T., Mathias, S., Montaner, J., & Wood, E. (2013). Homelessness independently predicts injection drug use initiation among street-involved youth in a Canadian setting. *Journal of Adolescent Health, 52*(4), 499-501. doi:10.1016/j.jadohealth.2012.07.011

Ferguson, K. M., Bender, K., Thompson, S., Xie, B., & Pollio, D. (2011). Correlates of street-survival behaviors in homeless young adults in four US cities. *American Journal of Orthopsychiatry, 81*(3), 401-409. doi:10.1111/j.1939-0025.2011.01108.x

Finfgeld-Connett, D. (2010). Becoming homeless, being homeless, and resolving homelessness among women. *Issues in Mental Health Nursing, 31*(7), 461-469. doi:10.3109/01612840903586404

Fowler, P. J., Toro, P. A., & Miles, B. W. (2009). Pathways to and from homelessness and associated psychosocial outcomes among adolescents leaving the foster care system. *American Journal of Public Heath, 99*(8), 1453-1458. doi:10.2105/AJPH.2008.142547

Franklin, B., Jones, A., Love, D., Puckett, S., Macklin, J., & White-Means, S. (2012). Exploring mediators of food insecurity and obesity: A review of recent literature. *Journal of Community Health, 37*(1), 253-264. doi:10.1007/s10900-011-9420-4

Galván, A. (2012). Risky behavior in adolescents: The role of the developing brain. In V. F. Reyna, S. B. Chapman, M. R. Dougherty, & J. Confrey (Eds.), *The adolescent brain: Learning, reasoning, and decision making* (pp. 267-289). doi:10.1037/13493-010

Ganz, D., & Sher, L. (2011). Adolescent suicide in New York City: Plenty of room for new research [Abstract]. *International Journal of Adolescent Medicine & Health, 24*(2), 99-104. doi:10.1515/ijamh.2012.015

Garzon, D. L., & Dunn, A. M. (2013). Developmental management of adolescents. In C. E. Burns, A. M. Dunn, M. A. Brady, N. B. Starr, & C. G. Blosser (Eds.), *Pediatric primary care* (5th ed.) [Kindle E-reader version]. Retrieved from http://www.amazon.com/Pediatric-Primary-Care-Burns-ebook/dp/B008ALUU4W/ref=tmm_kin_title_0

Gerber, G. (1997). Barriers to health care of street youth. *Journal of Adolescent Health, 21*(5), 287-290. doi:10.1016/S1054-139X(97)00111-0

Giedd, J. N. (2008). The teen brain: Insights from neuroimaging. *Journal of Adolescent Health, 42*(4), 335-343. doi:10.1016/j.jadohealth.2008.01.007

Giedd, J. N., Stockman, M., Weddle, C., Liverpool, M., Wallace, G. L., Raitano-Lee, N., . . . Lenroot, R. K. (2012). Anatomic magnetic resonance imaging of the developing child and adolescent brain. In V. F. Reyna, S. B. Chapman, M. R. Dougherty, & J. Confrey (Eds.), *The adolescent brain: Learning, reasoning, and decision making* (pp. 15-35). doi:10.1037/13493-001

Gomez, R., Thompson, S. J., & Barczyk, A. N. (2010). Factors associated with substance use among homeless young adults. *Substance Abuse, 31*(1), 24-34. doi:10.1080/08897070903442566

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105-112. doi:10.1016/j.nedt.2003.10.001

Greene, J. M., Ennett, S. T, & Ringwalt, C. L. (1997) Substance use among runaway and homeless youth in three national samples. *American Journal of Public Health, 87*(2), 229-235. doi:10.2105/AJPH.87.2.229

Greene, J. M., & Ringwalt, C. L. (1998). Pregnancy among three national samples of runaway and homeless youth. *Journal of Adolescent Health, 23*(6), 370-377. doi:10.1016/S1054-139X(98)00071-8

Gwadz, M. V., Nish, D., Leonard, N. R., & Strauss, S. M. (2007). Gender differences in traumatic events and rates of post-traumatic stress disorder among homeless youth. *Journal of Adolescence, 30*(1), 117-129. doi:10.1016/j.adolescence.2006.01.004

Hagedorn, S., & Ekegren, K. (2002). Caring for street youth: A nursing challenge. *Journal for Specialists in Pediatric Nursing, 7*(1), 34-37. doi:10.1111/j.1744-6155.2002.tb00146.x

Halcón, L. L., & Lifson, A. R. (2004). Prevalence and predictors of sexual risks among homeless youth [Abstract]. *Journal of Youth Adolescence, 33*(1), 71-80. doi:10.1023/A:1027338514930

Haldenby, A. M., Berman, H., & Forchuk, C. (2007). Homelessness and health in adolescents. *Qualitative Health Research, 17*(9), 1232-1244. doi:10.1177/1049732307550

Haley, N., Roy, E., Leclerc, P., Boudreau, J. F., & Boivin, J. F. (2004). Characteristics of adolescent street youth with a history of pregnancy [Abstract]. *Journal of Pediatric & Adolescent Gynecology, 17*(5), 313-320. doi:10.1016/j.jpag.2004.06.006

Hammer, H., Finkelhor, D., & Sedlak, A. J. (2002*). Runaway/thrownaway children: National estimates and characteristics*. National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children (NISMART), Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, to Temple University. Retrieved from https://www.ncjrs.gov/html/ojjdp/nismart/04/

Health Resources and Services Administration (HRSA). (2001). *Understanding the health care needs of homeless youth. Program assistance letter 2001-10*. Retrieved from http://bphc.hrsa.gov/policiesregulations/policies/pal200110.html

Healthy People.Gov. (2012). *Healthy people 2020: Adolescent health*. U.S. Department of Health and Human Services. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=2

Heerde, J. A., & Hemphill, S. A. (2013, June). Stealing and being stolen from: Perpetration of property offenses and property victimization among homeless youth-A systematic review. *Youth & Society*. doi:10.1177/0044118X13490763

Hein, L. C. (2011). Survival strategies of male homeless adolescents. *Journal of the American Psychiatric Nurses Association, 17*(4), 274-282. doi:10.1177/1078390311407913

Henning, D., Alice, R., Sanci, L., & Dunning, T. (2007). Screening for chlamydia trachomatis: Barriers for homeless young people. *Australian Journal of Advanced Nursing, 24*(3), 8-13. Retrieved from http://www.ajan.com.au/Vol24/Vol24.3-1.pdf

Hickler, B., & Auerswald, C. L. (2009). The worlds of homeless white and African American youth in San Francisco California: A cultural epidemiological comparison. *Social Science & Medicine, 68*(5), 824-831. doi:10.1016/j.socscimed.2008.12.030

Hodgson, K. J., Shelton, K. H., van den Bree, M. B. M., & Los. F. J. (2013). Psychopathology in young people experiencing homelessness: A systematic review. *American Journal of Public Health, 103*(6), e24-e37. doi:10.2105/AJPH.2013.301318

Homeless Emergency Assistance and Rapid Transition to Housing: Defining ‘‘Homeless.” 76 Fed. Reg. 75994 (December 5, 2011) (to be codified at 24 CFR pts. 91, 582, & 583). Available at: https://www.onecpd.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf

Hoyt, D. R., Ryan, K. D., & Cauce, A. M. (1999). Personal victimization in a high-risk environment: Homeless and runaway adolescents. *Journal of Research in Crime and Delinquency, 36*(4), 371-392. doi:10.1177/0022427899036004002

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. doi:10.1177/1049732305276687

Hudson, A. L. Nyamathi, A., Greengold, B., Slagle, A., Koniak-Griffin, D., Khalilifard, F., & Getzoff, D. (2010). Health seeking challenges among homeless youth. *Nursing Research, 59*(3), 212-218. doi:10.1097/NNR.0b013e3181d1a8a9

Hutchinson, S. A., Wilson, M. E., & Wilson, H. S. (1994). Benefits of participation in research interviews. *Image: The Journal of Nursing Scholarship, 26*(2), 161-166. doi:10.1111/j.1547-5069.1994.tb00937.x

Hyde, J. (2005). From home to street: Understanding young people's transitions into homelessness. *Journal of Adolescence, 28*(2), 171-183. doi:10.1016/j.adolescence.2005.02.001

Johnson, R. J., Rew, L., & Kouzekanani, K. (2006). Gender differences in victimized homeless adolescents. *Adolescence, 41*(161), 39-53.

Kavanaugh, K., & Ayres, L. (1998). "Not as bad as it could have been": Assessing and mitigating harm during research interviews on sensitive topics. *Research in Nursing & Health, 21*(1), 91-97. doi:10.1002/(SICI)1098-240X(199802)21:1<91::AID-NUR10>3.0.CO;2-C

Kidd, S. A., & Carroll, M. R. (2007). Coping and suicidality among homeless youth. *Journal of Adolescence, 30*(2), 283-296. doi:10.1016/j.adolescence.2006.03.002

Kidd, S. A., & Davidson, L. (2007). "You have to adapt because you have no other choice": The stories of strength and resilience of 208 homeless youth in New

York City and Toronto. *Journal of Community Psychology*, *35*(2), 219-238. doi:10.1002/jcop.20144

Kidd, S. A., & Kral, M. J. (2002). Suicide and prostitution among street youth: A qualitative analysis. *Adolescence*, *37*(146), 411-430.

Kim, H. S. (2010). *The nature of theoretical thinking in nursing* (3rd ed.). New York, NY: Springer.

Kipke, M. D., Simon, T. R., Montgomery, S. B., Unger, J. B., & Iversen, E. F. (1997). Homeless youth and their exposure to and involvement in violence while living on the streets. *Journal of Adolescent Health, 20*(5), 360-367. doi:10.1016/S1054-139X(97)00037-2

Kirst, M. J., Frederick, T., & Erickson, P. G. (2011). Concurrent mental health and substance use problems among street-involved youth [Abstract]. *International Journal of Mental Health and Addiction*, *9*(5), 543-553. doi:10.1007/s11469-011-9328-3

Klein, J. D., Woods, A. H., Wilson, K. M., Prospero, M., Greene, J., & Ringwalt, C. (2000). Homeless and runaway youths' access to health care. *Journal of Adolescent Health*, *27*(5), 331-339. doi:10.1016/S1054-139X(00)00146-4

Kozloff, N., Cheung, A. H., Ross, L. E., Winer, H., Ierfino, D., Bullock, H., & Bennett, K. J. (2013). Factors influencing service use among homeless youths with co-occurring disorders. *Psychiatric Services*, *64*(9), 925-928. doi:10.1176/appi.ps.201200257

Kral, A. H., Molnar, B. E., Booth, R. E., & Watters, J. K. (1997). Prevalence of sexual risk behaviour and substance use among runaway and homeless adolescents in

San Francisco, Denver and New York City. *International Journal of STD & AIDS, 8*(2), 109-117. doi:10.1258/0956462971919651

Krinsky, M. A. (2010). A not so happy birthday: The foster youth transition from adolescence into adulthood. *Family Court Review, 48*(2), 250-254. doi:10.1111/j.1744-1617.2010.01306.x

Krippendorff, K. (2013). *Content analysis: An introduction to its methodology* (3rd ed.). Los Angeles, CA: Sage.

Landis, A. M., Parker, K. P., & Dunbar, S. B. (2009). Sleep, hunger, satiety, food cravings, and caloric intake in adolescents. *Journal of Nursing Scholarship, 41*(2), 115-125. doi:10.1111/j.1547-5069.2009.01262.x

Lee, B. A., Tyler, K. A., & Wright, J. D. (2010). The new homelessness revisited. *Annual Review of Sociology, 36*, 501-521. doi:10.1146/annurev-soc-070308-115940

Li, A., Dachner, N., & Tarasuk, V. (2009). Food intake patterns of homeless youth in Toronto. *Canadian Journal of Public Health, 100*(1), 36-40. Retrieved from http://journal.cpha.ca/index.php/cjph/article/viewArticle/1734

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage.

Lindsey, E. W., Kurtz, P. D., Jarvis, S. Williams, N. R., & Nackerud, L. (2000). How runaway and homeless navigate troubled waters: Personal strengths and resources. *Child & Adolescent Social Work Journal, 17*(2), 115-140. doi:10.1023/A:1007558323191

Lutz, K. F., Shelton, K. C., Robrecht, L. C., Hatton, D. C., & Beckett, A. K. (2000). Use of certificates of confidentiality in nursing research. *Journal of Nursing Scholarship, 32*(2), 185-188. doi:10.1111/j.1547-5069.2000.00185.x

MacLean, L. M., Meyer, M., & Estable, A. (2004). Improving accuracy of transcripts in qualitative research. *Qualitative Health Research, 14*(1), 113-123. doi:10.1177/1049732303259804

Mallett, S., Rosenthal, D., & Keys, D. (2005). Young people, drug use and family conflict: Pathways into homelessness. *Journal of Adolescence, 28*(2), 185-199. doi:10.1016/j.adolescence.2005.02.002

Mallett, S., Rosenthal, D., Myers, P., Milburn, N., & Rotheram-Borus, M. J. (2004). Practising homelessness: A typology approach to young people's daily routines. *Journal of Adolescence, 27*(3), 337–349. doi:10.1016/j.adolescence.2003.11.014

Marecek, J. (2003). Dancing through minefields: Toward a qualitative stance in psychology. In P. M Camic, J. E. Rhodes, & L .Yardley, (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design.* (pp. 46-49). Washington, DC: American Psychological Association.

Marecek, J., Fine, M., & Kidder, L. (1997). Working between worlds: Qualitative methods and social psychology. *Journal of Social Issues, 53*(4), 631-644. doi:10.1111/j.1540-4560.1997.tb02452.x

Martijn, C., & Sharpe, L. (2006). Pathways to youth homelessness. *Social Science & Medicine, 62*(1), 1-12. doi:10.1016/j.socscimed.2005.05.007

Martinez, R. J. (2006). Understanding runaway teens. *Journal of Child and Adolescent Psychiatric Nursing, 19*(2), 77–88. doi:10.1111/j.1744-6171.2006.00049.x

MassLegalHelp, (2013) *SNAPs and homelessness.* Retrieved from http://www.masslegalhelp.org/income-benefits/fshomelessness

McManus, H. H., &Thompson, S. J. (2008). Trauma among unaccompanied homeless youth: The integration of street culture into a model of intervention. *Journal of Aggression, Maltreatment &Trauma, 16*(1), 92-109. doi:10.1080/10926770801920818

McMorris, B. J., Tyler, K. A., Whitbeck, L. B., & Hoyt, D. R. (2002). Familial and "on-the-street" risk factors associated with alcohol use among homeless and runaway adolescents [Abstract]. *Journal of Studies on Alcohol, 63*(1), 34-43. Retrieved from http://www.jsad.com/jsad/downloadarticle/Familial_and_ OntheStreet_Risk_Factors_Associated_with_Alcohol_Use_among/1438.pdf

Milburn, N. G., Rosenthal, D., Rotheram-Borus, M. J., Mallett, S., Batterham, P., Rice, E., & Solorio, R. (2007). Newly homeless youth typically return home. *Journal of Adolescent Health, 40*(6), 574-576. doi:10.1016/j.jadohealth.2006.12.017

Molino, A. C. (2007). *Characteristics of help-seeking street youth and non-street youth.* Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research. Retrieved from http://aspe.hhs.gov/hsp/homelessness/symposium07/molino/

Morse, J. M. (2011). What is qualitative health research? In N. S. Denzin, & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research,* (4th ed., pp. 401-414). Los Angeles, CA: Sage.

Moskowitz, A., Stein, J. A., & Lightfoot, M. (2012). The mediating roles of stress and maladaptive behaviors on self-harm and suicide attempts among runaway and homeless youth. *Journal of Youth & Adolescence,* 1-13. doi:10.1007/s10964-012-9793-4

National Alliance to End Homelessness, (2012). *An emerging framework for ending unaccompanied youth homelessness* (Report). Retrieved from http://www.endhomelessness.org/library/entry/an-emerging-framework-for-ending-unaccompanied-youth-homelessness

National Alliance to End Homelessness. (2013). *Snapshot of homelessness*. Retrieved from http://www.endhomelessness.org/pages/snapshot_of_homelessness

National Alliance to End Homelessness. (2013, April). *State of homelessness in America 2013. An examination of homelessness, economic, housing, and demographic trends at the national and state levels.* Retrieved from http://www.endhomelessness.org/library/entry/the-state-of-homelessness-2013

National Center for Homeless Education. (2013). *Education for homeless children and youths program: Data collection summary.* Retrieved from http://center.serve.org/nche/downloads/data-comp-0910-1112.pdf

National Center on Family Homelessness. (2008). *The characteristics and needs of families experiencing homelessness.* Retrieved from http://www.familyhomelessness.org/media/147.pdf

National Center on Family Homelessness. (2011). Rhode Island. In *America's youngest outcasts 2010: State report card on child homelessness* (p. 64). Retrieved from http://www.homelesschildrenamerica.org/media/NCFH_AmericaOutcast2010_web_032812.pdf

National Coalition for the Homeless. (2008). *Fact sheets: Homeless youth*. Retrieved from http://www.nationalhomeless.org/factsheets/youth.html

National Coalition for the Homeless. (2009a). *Factsheets: How many people experience homelessness?* Retrieved from http://www.nationalhomeless.org/factsheets/How_Many.html

National Coalition for the Homeless. (2009b). *Factsheets: Who is homeless?* Retrieved from: http://www.nationalhomeless.org/factsheets/who.html

National Coalition for the Homeless. (2009c). *Factsheets: Why are people homeless?* Retrieved from: http://www.nationalhomeless.org/factsheets/why.html.

National Coalition for the Homeless. (2009d). *Factsheets: Homeless families with children*. Retrieved from: http://www.nationalhomeless.org/factsheets/families.html

National Coalition for the Homeless. (n.d.). *Factsheet: The census and homelessness.* Retrieved from: http://www.nationalhomeless.org/factsheets/CensusFactSheet.pdf

National Conference of State Legislatures. (2013). *Homeless and runaway youth*. Retrieved from http://www.ncsl.org/issues-research/human-services/homeless-and-runaway-youth.aspx

National Health Care for the Homeless Council. (n.d.). *What is the definition of homelessness?* Accessed at http://www.nhchc.org/faq/official-definition-homelessness/

National Network for Youth. (n.d.a). *Unaccompanied youth - fast facts* [NN4Y Issue Brief]. Retrieved from http://www.nn4youth.org/system/files/FactSheet_Unacompanied_Youth_0.pdf

National Network for Youth. (n.d.b). *Youth homelessness* [NN4Y Issue Brief]. Retrieved from http://www.nn4youth.org/system/files/IssueBrief_Youth_Homelessness.pdf

National Runaway Safeline. (2013). Crisis connection trend report fact sheet. Retrieved from http://www.1800runaway.org/assets/1/7/2002_-_2012_Crisis_Caller_Trend_Report_Fact_Sheet.pdf

Nesmith, A. (2006) Predictors of running away from family foster care. *Child Welfare, 85*(3), 585-609.

Newman, B., & Newman, P. (2012). *Development through life: A psychosocial approach* (11th ed.). Belmont, CA: Wadsworth Cengage Learning.

Nyamathi, A., Hudson, A., Greengold, B., Slagle, A., Marfisee, M., Khalilifard, F., & Leake, B. (2010). Correlates of substance use severity among homeless youth. *Journal of Child and Adolescent Psychiatric Nursing*, *23*(4), 214-222. doi:10.1111/j.1744-6171.2010.00247.x

Nyamathi, A., Marfisee, M., Slagle, A., Greengold, B., Liu, Y., & Leake, B. (2012). Correlates of depressive symptoms among homeless young adults [Abstract]. *Western Journal of Nursing Research, 34*(1), 97-117. doi:177/01939-459103889480.1

O'Neill, T. C. (2013, May 13). *23,000 Rhode Island children live in extreme poverty*. Accessed at www.golocalprov.com/news/23000-rhode-island-children-live-in-extreme-poverty-RI-kids-count/

O'Sullivan, J., & Lussier-Duynstee, P. (2006). Adolescent homelessness, nursing, and public health policy. *Policy, Politics, & Nursing Practice, 7*(1), 73-77. doi:10.1177/1527154406286663

Oliveira, J. O., & Burke, P. J. (2009). Lost in the shuffle: Culture of homeless adolescents. *Pediatric Nursing, 35*(3), 154-161.

Oliver, V. (2013). *Healing home: Health and homelessness in the life stories of young women*. Canada: University of Toronto Press.

Oliver, V., & Cheff, R. (2012). The social network: Homeless young women, social capital, and the health implications of belonging outside the nuclear family. *Youth & Society*. doi:10.1177/0044118X12448801

Ott, M. A., Rosenberger, J. G., McBride, K. R., & Woodcox, S. G. (2001). How do adolescents view health? Implications for state health policy. *Journal of Adolescent Health, 48*(4), 398-403. doi:10.1016/j.jadohealth.2010.07.019

Parse, R. R. (2001). The qualitative descriptive method. In *Qualitative inquiry: The path of sciencing*, (pp. 57-60). Sudbury, MA: Jones & Bartlett.

Perez, B. F., & Romo, H. D. (2011). "Couch surfing" of Latino foster care alumni: Reliance on peers as social capital. *Journal of Adolescence, 34*(2), 239-248. doi: 10.1016/j.adolescence.2010.05.007

Pergamit, M. R., & Ernst, M. (2010). *Runaway youth's knowledge and access of services.* Retrieved from National Runaway Safeline website:

http://www.1800runaway.org/media/documents/NORC_Final_Report_4_22_10.pdf

Polit, D. F., & Beck Tatano, C. (2008). Enhancing quality and integrity in qualitative research. In *Nursing research: Generating and assessing evidence for nursing practice* (8th ed., pp. 536-555). Philadelphia, PA: Wolters Kluwer/Lippincott Williams & Wilkins.

Rafferty, Y., Shinn, M., & Weitzman, B. C. (2004). Academic achievement among formerly homeless adolescents and their continuously housed peers. *Journal of School Psychology, 42*(3), 179-199. doi:10.1016/j.jsp.2004.02.002

Ray, N. (2006). *Lesbian, gay, bisexual, and transgender youth: An epidemic of homelessness.* New York, NY: National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless. Retrieved from National Gay and Lesbian Task Force Foundation website: http://www.thetaskforce.org/downloads/HomelessYouth.pdf

Reid, S., Berman, H., & Forchuk, C. (2005). Living on the streets in Canada: A feminist narrative study of girls and young women. *Issues in Comprehensive Pediatric Nursing, 28*(4), 237-256. doi:10.1080/01460860500396906

Rew, L. (1996). Health risks of homeless adolescent: Implications for holistic nursing. *Journal of Holistic Nursing, 14*(4), 348-359. doi:10.1177/089801019601400407

Rew, L. (2003). A theory of taking care of oneself grounded in experiences of homeless youth. *Nursing Research, 52*(4), 234-241.

Rew, L. (2008). Caring for and connecting with homeless adolescents. *Family and Community Health, 31*(Suppl. 1), 42-51. doi:10.1097/01.FCH.0000304017.13255.12.

Rew, L., Chambers, K. B., & Kulkarni, S. (2002). Planning a sexual health promotion intervention with homeless adolescents. *Nursing Research, 51*(3), 168-174.

Rew, L., Fouladi, R. T., & Yockey, R. D. (2001). Sexual health practices of homeless youth. *Journal of Nursing Scholarship, 34*(2), 139-145. doi:10.1111/j.1547-5069.2002.00139.x

Rew, L., & Horner, S. D. (2003a). Personal strengths of homeless adolescents living in a high-risk environment. *Advances in Nursing Science, 26*(2), 90-101.

Rew, L. & Horner, S. D. (2003b). Youth resilience framework for reducing health-risk behaviors in adolescents. *Journal of Pediatric Nursing, 18*(6), 379-388. doi:10.1016/S0882-5963(03)00162-3

Rew, L., Taylor-Seehafer, M., & Fitzgerald, M. L. (2001). Sexual abuse, alcohol, and other drug use and suicidal behaviors in homeless adolescents. *Issues in Comprehensive Pediatric Nursing, 24*(4), 225-240. doi:10.1080/014608601753260326

Rew, L., Taylor-Seehafer, M, Thomas, N. Y., & Yockey, R. D. (2001). Correlates of resilience in homeless adolescents. *Journal of Nursing Scholarship 33*(1), 33-40. doi:10.1111/j.1547-5069.2001.00033.x

Rew, L., Whittaker, T. A., Taylor-Seehafer, M. A., & Smith, L. R. (2005). Sexual health risks and protective resources in gay, lesbian, bisexual, and heterosexual

homeless youth. *Journal for Specialists in Pediatric Nursing, 10*(1), 11-19. doi:10.1111/j.1088-145X.2005.00003.x

Reyna, V. F., Chapman, S. B., Dougherty, M. R. & Confrey, J. (2012). Introduction to the adolescent brain: Learning, reasoning, and decision making. In *The adolescent brain: Learning, reasoning, and decision making* (pp. 3-14). Washington, DC: American Psychological Association.

Rhode Island Coalition for the Homeless. (n.d.). *Homeless in Rhode Island: An overview of the homeless crisis and proposed solutions*. Retrieved from http://www.rihomeless.org/Portals/0/Uploads/Documents/Public/Overview%20of%20Homelessness%20updated.pdf

Rhode Island Coalition for the Homeless. (2012). *Statistics on the homeless in Rhode Island.* Retrieved from http://www.rihomeless.org/AboutHomelessness/HomelessnessStatistics/tabid/248/Default.aspx

Rice, E., Barman-Adhikari, A., Rhoades, H., Winetrobe, H., Fulginiti, A., Astor, R., ... & Kordic, T. (2013). Homelessness experiences, sexual orientation, and sexual risk taking among high school students in Los Angeles. *Journal of Adolescent Health. 52*(6), 773-778. doi:10.1016/j.jadohealth.2012.11.011

Rice, E., Monro, W., Barman-Adhikari, A., & Young, S. D. (2010). Internet use, social networking, and HIV/AIDS risk for homeless adolescents. *Journal of Adolescent Health, 47*(6), 610-613. doi:10.1016/j.jadohealth.2010.04.016

Richards, L., & Morse, J. M. (2007). *User's guide to qualitative methods* (2nd ed.). Thousand Oaks, CA: Sage.

Richards, R., Smith, C., & Eggett, D. L. (2013). Correlates of energy intake and body mass index among homeless children in Minnesota. *Childhood Obesity, 9*(3), 240-251. doi:10.1089/chi.2012.0026

Richardson, E., Sellors, J. W., Mackinnon, S., Woodcox, V., Howard, M., Jang, D., & Chernesky, M. A. (2003). Prevalence of Chlamydia trachomatis infections and specimen collection preference among women, using self-collected vaginal swabs in community settings. *Sexually Transmitted Diseases, 30*(12), 880-885. doi:10.1097/01.OLQ.0000091142.68884.2A

Riessman, C. K. (1993). *Narrative analysis. Qualitative research methods series, No. 30*. Newbury Park, CA: Sage.

Ringwalt, C. K., Greene, J. L., Robertson, M., & McPheeters, M. (1998). The prevalence of homelessness among adolescents in the United States. *American Journal of Public Health, 88*(9), 1325-1329. doi:10.2105/AJPH.88.9.1325

Robert, M., Pauzé, R., & Fournier, L. (2005). Factors associated with homelessness of adolescents under supervision of the youth protection system. *Journal of Adolescence, 28*(2), 215–230. doi:10.1016/j.adolescence.2005.02.004

Robertson, M. J., & Toro, P. A. (1999). Homeless youth: Research, intervention, and policy. In L. B. Fosburgh & D. L. Dennis (Eds.), *Practical lessons: The 1998 national symposium on homelessness research*. Retrieved from The Internet Archive website: https://archive.org/details/practicallessons00usde

Rohde, P., Noell, J., Ochs, L., & Seeley, J. R. (2001). Depression, suicidal ideation and STD-related risk in homeless older adolescents. *Journal of Adolescence, 24*(4), 447-460. doi:10.1006/jado.2001.0382

Saewyc, E. M. (2011). Health promotion of the adolescent and family. In M. Hockenberry, & D. Wilson (Eds.), *Wong's nursing care of infants and children* (9th ed., pp. 745-747). St. Louis, MO: Elsevier.

Sanchez, R. P, Waller, M. W., & Greene, J. M. (2006). Who runs? A demographic profile of runaway youth in the United States. *Journal of Adolescent Health, 39*(5), 778-781. doi:10.1016/j.jadohealth.2006.04.018

Sandelowski, M. (1998). Writing a good read: Strategies for re-presenting qualitative data. *Research in Nursing & Health*, *21*(4), 375-382. doi:10.1002/(SICI)1098-240X(199808)21:4<375::AID-NUR9>3.0.CO;2-C

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*(4), 334-340. doi:10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Sandelowski, M., & Leeman, J. (2012). Writing usable qualitative health research findings. *Qualitative Health Research, 22*(10), 1404-1413. doi:10.1177/1049732312450368

Schilling, J. (2006). On the pragmatics of qualitative assessment: Designing the process for content analysis. *European Journal of Psychological Assessment, 22*(1), 28-37. doi:10.1027/1015-5759.22.1.28

Schmitz, R. M. (2013). *Tentative transitions and gendered pathways: Exploring the revolving door of young adult homelessness* (Master's thesis). Retrieved from http://digitalcommons.unl.edu/sociologydiss/23/

Schreier, M. (2012). *Qualitative content analysis in practice.* Los Angeles, CA: Sage.

Seidman, I. E. (2006). *Interviewing as qualitative research: A guide for researcher in education and the social sciences* (2nd ed.). New York, NY: Teachers College Press.

Sermons, M. W., Witte, P. (2011, January). State of homelessness in America: A research report on homelessness. Retrieved from http://www.endhomelessness.org/library/entry/state-of-homelessness-in-america-2011

Slesnick, N., & Meade, M. (2001). System youth: A subgroup of substance-abusing homeless adolescents. *Journal of Substance Abuse*, *13*(3), 367-384. doi:10.1016/S0899-3289(01)00082-7

Smid, M., Bourgois, P., & Auerswald, C. L. (2010). The challenge of pregnancy among homeless youth: Reclaiming a lost opportunity. *Journal of Health Care for the Poor & Underserved*, *21*(Suppl. 2), 140-156. doi:10.1353/hpu.0.0318

Son, A. J. (2002). *Information packet: Runaway and homeless youth*. New York, NY: Hunter College School of Social Work, National Resource Center for Foster Care and Permanency Planning. Retrieved from Hunter College School of Social Work website: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/information_packets/homeless_and_runaway_youth-pkt.pdf

Speziale, H. J., & Rinaldi Carpenter, D. (2007). The conduct of qualitative research: Common essential elements. In *Qualitative research in nursing: Advancing the humanistic imperative* (5th ed., pp. 18-33). Philadelphia, PA: Lippincott, Williams & Wilkins.

Stewart, A. J., Steiman, M., Cauce, A. M., Cochran, B. N., Whitbeck, L. B., & Hoyt, D. R. (2004). Victimization and posttraumatic stress disorder among homeless adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(3), 325-331. doi:10.1097/00004583-200403000-00015

Tarasuk, V., Dachner, N., & Li, J. (2005). Homeless youth in Toronto are nutritionally vulnerable. *The Journal of Nutrition, 135*(8), 1926-1933. Retrieved from http://jn.nutrition.org/content/135/8/1926.full

Taylor-Powell, E., & Renner, M. (2003). *Analyzing qualitative data*. Program Development and Evaluation. Madison, WI: University of Wisconsin--Extension, Cooperative Extension. Retrieved from http://learningstore.uwex.edu/assets/pdfs/g3658-12.pdf

Taylor-Seehafer, M. A. (2004). Positive youth development: Reducing the health risks of homeless youth. *MCN: The American Journal of Maternal/Child Nursing, 29*(1), 36-40.

Tenner, A. D., Trevithick, L. A., Wagner, V., & Burch, R. (1998). Seattle YouthCare's prevention, intervention, and education program: A model of care for HIV-positive, homeless, and at-risk youth. *Journal of Adolescent Health, 23*(2), 96-106. doi:10.1016/S1054-139X(98)00057-3

Teruya, C., Longshore, D. Andersen, R. M., Arangua, L. Nyamathi, A, & Leake, B. (2010). Health and health care disparities among homeless women [Abstract]. *Women & Health, 50*(8), 719-736. doi:10.1080/03630242.2010.532754

The United States Conference of Mayors. (2012). *Hunger and homelessness survey. A status report on hunger and homelessness in America's cities: A 25-city survey*. Retrieved from http://usmayors.org/pressreleases/uploads/2012/1219-report-HH.pdf

Thompson, R., Proctor, L. J., English, D. J., Dubowitz, H., Narasimhan, S., & Everson, M. D. (2012). Suicidal ideation in adolescence: Examining the role of recent adverse experiences. *Journal of Adolescence*, *35*(1), 175-186. doi:10.1016/j.adolescence.2011.03.003

Thompson, S. J., Bender, K. A., Lewis, C. M., & Watkins, R. (2008). Runaway and pregnant: Risk factors associated with pregnancy in a national sample of runaway/homeless female adolescents. *Journal of Adolescent Health*, *43*(2), 125-132. doi:10.1016/j.jadohealth.2007.12.015

Thompson, S. J., Ryan, T. N., Montgomery, K. L., Lippman, A. D. P., Bender, K., & Ferguson, K. (2013). Perceptions of resiliency and coping: Homeless young adults speak out. *Youth & Society*. doi:10.1177/0044118X13477427

Toro, P. A., Lesperance, T. M., & Braciszewski, J. M. (2011). *The heterogeneity of homeless youth in America: Examining typologies*. Retrieved from National Alliance to End Homelessness website: http://b.3cdn.net/naeh/29187fa2fa05e03e4a_ysm6b8861.pdf

Tyler, K. A. (2006). A qualitative study of early family histories and transitions of homeless youth. *Journal of Interpersonal Violence, 21*(10), 1385-1393. doi:10.1177/0886260506291650

Tyler, K. A. (2008). A comparison of risk factors for sexual victimization among gay, lesbian, bisexual, and heterosexual homeless young adults. *Violence & Victims, 23*(5), 586-602. doi:10.1891/0886-6708.23.5.586

Tyler, K. A. (2009). Risk factors for trading sex among homeless young adults [Abstract]. *Archives of Sexual Behavior, 38*(2), 290-297. doi:10.1007/s10508-007-9201-4

Tyler, K. A., & Cauce, A. M. (2002). Perpetrators of early physical and sexual abuse among homeless and runaway adolescents. *Child Abuse & Neglect 26*(12), 1261-1274. doi:10.1016/S0145-2134(02)00413-1

Tyler, K. A., Gervais, S. J., & Davidson, M. M. (2013). The relationship between victimization and substance use among homeless and runaway female adolescents. *Journal of Interpersonal Violence*, *28*(3), 474-493. doi:10.1177/0886260512455517

Tyler, K. A., Hagewen, K. J., & Melander, L. A. (2011). Risk factors for running away among a general population sample of males and females. *Youth & Society, 43*(2), 583-608. doi: 10.1177/0044118X11400023

Tyler, K. A., & Johnson, K. A. (2006). Trading sex: Voluntary or coerced? The experiences of homeless youth. *Journal of Sex Research, 43*(3), 208-216. doi:10.1080/00224490609552319

Tyler, K. A., & Melander, L. A. (2010). Foster care placement, poor parenting, and negative outcomes among homeless young adults. *Journal of Child and Family Studies*, *19*(6), 787-794. doi: 10.1007/s10826-010-9370-y

Tyler, K. A., Schmitz, R. M. (2013). Family histories and multiple transitions among homeless young adults: Pathways to homelessness. *Children and Youth Services Review, 35*(10), 1719-1726. doi:10.1016/j.childyouth.2013.07.014

Tyler, K. A., Whitbeck, L. B., Hoyt, D. R., & Cauce, A. M. (2004). Risk factors for sexual victimization among male and female homeless and runaway youth. *Journal of Interpersonal Violence, 19*(5), 503-520. doi:10.1177/0886260504262961

United Nations. (2007). *World youth report. Young people's transitions to adulthood: Progress and challenges*. Retrieved from http://www.un.org/esa/socdev/unyin/documents/wyr07_complete.pdf

U.S. Census. (2008). Retrieved from http://www.census.gov/popest/data/historical/2000s/vintage_2008/index.html

U.S. Department of Agriculture: Food and Nutrition Services. (2013). *Supplemental nutrition assistance program (SNAP).* Retrieved from http://www.fns.usda.gov/snap

U.S. Department of Agriculture: Food and Nutrition Services. (2013). *SNAP - Clarification of policies barriers facing homeless youth.* Retrieved from http://origin.www.fns.usda.gov/snap/outreach/pdfs/Policy_Clarifications_Homeless_Youth_Issues.pdf

U.S. Department of Health and Human Services, Administration of Children and Families. (2010). NEORHYMIS Street Outreach Program. National Extranet Optimized Runaway and Homeless Youth Management Information System (NEO-RHYMIS). Retrieved from

https://extranet.acf.hhs.gov/rhymis/dev/StdSOPGetParams.jsp?title=Street%20Outreach%20Program&uri=Std_SOP

U.S. Department of Health and Human Services. (n.d.). *Adolescent brain development,* [module]. Retrieved from http://www.hhs.gov/opa/familylife/tech_assistance/etraining/adolescent_brain/index.html

U.S. Department of Housing and Urban Development (2012) *Continuum of Care Homeless Assistance Programs Homeless population and subpopulations*. Accessed at https://www.onecpd.info/reports/CoC_PopSub_NatlTerrDC_2012.pdf

U.S. Department of Housing and Urban Development. (2013) Homeless Resource exchange. Accessed at www.hudhre.info/index.cfm?do=viewhomelessrpts

U.S. Interagency Council on Homelessness. (2010). *Opening doors: Federal strategic plan to prevent and end homelessness.* Retrieved from http://www.epaperflip.com/aglaia/viewer.aspx?docid=1dc1e97f82884912a8932a3502c37c02

U.S. Interagency Council on Homelessness. (2012). *Opening doors: Federal strategic plan to end homelessness. Update 2012.* Retrieved from http://usich.gov/resources/uploads/asset_library/Update2012_FINALweb.pdf

U.S. Interagency Council on Homelessness. (2013). *The 2013 point in time count and beyond*. Retrieved from http://usich.gov/member_agency/department_of_housing_and_urban_development/point_in_time_count

U.S. Preventive Services Task Force. (n.d.). *Child and adolescent recommendations*. Retrieved from http://www.uspreventiveservicestaskforce.org/tfchildcat.htm

Usher, K. J., & Arthur, D. (1998). Process consent: A model for enhancing informed consent in mental health nursing. *Journal of Advanced Nursing, 27*(4), 692-697. doi:10.1046/j.1365-2648.1998.00589.x

van den Bree, M. B., Shelton, K., Bonner, A., Moss, S., Thomas, H., & Taylor, P. J. (2009). A longitudinal population-based study of factors in adolescence predicting homelessness in young adulthood. *Journal of Adolescent Health, 45*(6), 571-578. doi:10.1016/j.jadohealth.2009.03.027

Van Leeuwen, J. M., Boyle, S. Salomonsen-Sautel, S., Baker, D. N., Garcia, J. T., Hoffman, A., & Hopfer, C. J. (2005). Lesbian, gay, and bisexual homeless youth: An eight-city public health perspective. *Child Welfare, 85*(2), 151-170.

Washington, P. S. (2011). Homeless youth: A concept analysis. *Journal of Community Health Nursing, 28*(3), 168-178. doi:10.1080/07370016.2011.589244

Whitbeck, L. B., Chen, X., Hoyt, D. R., Tyler, K. A., & Johnson, K. D. (2004). Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and runaway adolescents. *Journal of Sex Research, 41*(4), 329-342. doi:10.1080/00224490409552240

Whitbeck, L. B., Chen, X., & Johnson, K. D. (2006). Food insecurity among homeless and runaway adolescents. *Public Health Nutrition, 9*(1), 47-52. doi:10.1079/PHN2005764

Whitbeck, L. B., & Hoyt, D. R. (1999). *Nowhere to grow: Homeless and runaway adolescents and their families*. New York, NY: Walter de Gruyter.

Whitbeck, L. B., Hoyt, D. R., & Ackely, K. A. (1997). Families of homeless and runaway adolescents: A comparison of parent/caretaker and adolescent perspectives on parenting, family violence, and adolescent conduct. *Child Abuse and Neglect, 21*(6). 517-528. doi:10.1016/S0145-2134(97)00010-0

Whitbeck, L. B., Johnson, K. D., Hoyt, D. R., & Cauce, A. M. (2004). Mental disorder and comorbidity among runaway and homeless adolescents. *Journal of Adolescent Health, 35*(2), 132-140. doi:10.1016/j.jadohealth.2003.08.011

White, C. R., Gallegos, A. H., O'Brien, K., Weisberg, S., Pecora, P. J., & Medina, R. (2011). The relationship between homelessness and mental health among alumni of foster care: Results from the Casey Young adult survey. *Journal of Public Child Welfare, 5*(4), 369-389. doi:10.1080/15548732.2011.599754

Widome, R., Neumark-Sztainer, D., Hannan, P. J., Haines, J., & Story, M. (2009). Eating when there is not enough to eat: Eating behaviors and perceptions of food among food-insecure youths. *American Journal of Public Health, 99*(5), 8722-828. doi:10.2105/AJPH.2008.139758

Williams, N. R., & Lindsey, E. (2005). Spirituality and religion in the lives of runaway and homeless youth: Coping with adversity. *Journal of Religion and Spirituality in Social Work: Social Thought, 24*(4), 19-38. doi:10.1300/J377v24n04_03

World Health Organization (WHO). (2012). *Adolescent development. Programmes and Projects. Maternal, newborn, child and adolescent health*. Retrieved from WHO website: http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/index.html

World Health Organization (WHO). (2013) *Adolescent development: A critical transition.* Retrieved from WHO website: www.who.int/maternal_child_ adolescent/topic/adolescence/dev/en/index.html

Yen, I. H., Hammond, W. P., & Kushel, M. B. (2009). From homeless to hopeless and healthless?: The health impacts of housing challenges among former foster care youth transitioning to adulthood in California. *Issues in Comprehensive Pediatric Nursing, 32*(2), 77-93. doi:10.1080/01460860902740982

Yoder, K. A., Hoyt, D. R., & Whitbeck, L. B. (1998). Suicidal behavior among homeless and runaway adolescents. *Journal of Youth and Adolescence, 27*(6), 753-771. doi:10.1023/A:1022813916476

Zoltnick, C. (2009). What research tells us about the intersecting streams of homelessness and foster care. *Journal of Orthopsychiatry, 79*(3), 319-325. doi:10.1037/a0017218